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 _____	R-C 12/15/2022

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 000	Initial Comments A Revisit Survey was conducted at this facility on December 14 -15, 2022 as a follow up to the recertification survey of September 26, 2022. Survey activities consisted of observations, record reviews, and resident and staff interviews. The facility's census during the survey was 214 and the survey sample included 30 residents. The following incidents were investigated during this survey: DC00011315 and DC00011319 Federal and/or Local deficiencies were cited related to the investigation(s) of : DC00011319 After analysis of the findings, it was determined that the facility was not in compliance with t22B District of Columbia Municipal Regulations Chapter 32 requirements for Long Term Care Facilities. The following is a directory of abbreviations and/or acronyms that may be utilized in the report: The following is a directory of abbreviations and/or 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	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.	

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 _____	R-C 12/15/2022

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 000	Continued From page 1	L 000		

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 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

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 _____	R-C 12/15/2022

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 000	Continued From page 2 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	L 000		
{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 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;	{L 052}		

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 _____	R-C 12/15/2022

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 3 (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 observations, record reviews, and staff interviews, in three (3) of 3 observations, and for three of 30 sampled residents, facility staff failed to ensure that sufficient nursing time was provided to: protect residents from accidents and hazards; assess/reassess Resident #9's elevated blood pressure in a timely manner; and administer two (2) residents blood pressure medications in accordance with the physician's orders. Residents' #6, #158, #9, #4 and #189.	{L 052}		

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 _____	R-C 12/15/2022

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 4 The findings included: Review of the facility's Plan of Correction with a compliance date of 12/05/22 documented, " ...Staff Educator/Designee will ... in-service on the importance of accurate medication administration as ordered by the physician. Education will be completed by 12/5/2022; and ... a house wide audit of all the 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 ..." 1. Facility staff failed to keep a blister pack of 13 tablets of Donepezil (medication used to treat dementia) out of residents reach on unit 1 south. During a tour of unit 1 south on 12/14/22 at 10:59 AM, the surveyor entered room 112 B to conduct a wound dressing observation. As the surveyor was entering the room, Employee #4 (Registered Nurse/RN) was observed passing out medications. At 11:20 AM, as the surveyor was walking out of room 122, a blister pack containing 13 tablets of Donepezil was observed on the hallway floor, as residents walked by. The surveyor picked up the medication and walked to the nurse's station, where the medication cart was observed parked, and Employee #4 was sitting. During a face-to-face interview conducted on 12/14/22 at 11:21 AM, it was brought to Employee #4's attention that a blister pack of medication was found on the floor, causing a hazard risk. Employee #4 stated, "I'm sorry. I didn't see when	{L 052}	L052 **1. CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** No resident was affected due to this deficient practice. Resident #6 and Resident #158 received their scheduled medications with no negative outcome. A Head-to-toe assessment was done for Resident #4 and Resident #189 by the Licensed nurse on 12.23.22 and suffered no negative outcomes from this deficient practice. As stated herein, it should be noted that there was no evidence that Resident #9 suffered any untoward outcome. Employee#4 and Employee#10 were educated by the Staff educator/designee on 12/14/22 and 12/20/22 respectively on medication administration, appropriate disposal and destruction of medications that are refused and appropriate storage of medications. Employee#8 was educated on 12/14/2022 on medication administration which included assessing vital signs for residents on blood pressure medications, timely medication administration, and prompt documentation. A house-wide in-service was completed for all licensed nurses on 1/1/2023 on Medication administration. **2. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** A house wide audit was completed on 12/21/22 by Unit Managers to ensure all medications were safely stored. Any negative findings were corrected upon discovery All residents who receive Midodrine Medication have the potential to be affected. Unit Managers/Designee conducted a house wide audit completed on 12/16/22 of all the residents on Midodrine medication to ensure that Midodrine is administered as prescribed by the physician. For negative findings discovered during the audit, disciplinary action with education was done for the staff by the Staff educator/designee.	

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 _____	R-C 12/15/2022

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 5 it fell." 2. Facility staff failed to maintain a safe environment during medication administration observation conducted on unit 3 South (secured unit with residents who have advanced dementia) as evidenced by leaving medications unattended on top of the medication cart. Residents' #6 and #158. According to Title 42 CFR § 483.45 Pharmacy services. "(h) Storage of drugs and biologicals. (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." https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-483/subpart-B/section-483.45 During a medication observation on Unit 3 South on 12/14/2022 at approximately 11:20AM, Employee #10 (Registered Nurse, Supervisor) was observed preparing to give medications to Resident #6. At this time, an unlabeled disposable souffle cup containing 4 pills was observed on the medication cart. Employee #10 was asked who the medications belong to? She answered, [Resident #158]. Employee #10 then continued to prepare medications for Resident #6, locked the medication cart and proceeded to enter the room of Resident #6. While in Resident #6's room, Employee #10 was observed out of direct line of eyesight of the medications left on the cart. At the time of the observation two (2) residents were seated in close proximity to the medication cart. During a face-to-face interview with Employee	{L 052}	**3. MEASURE TO PREVENT REOCURRENCE** Education was completed for all licensed nurses by the Staff educator/designee on 01/01/23 on medication administration, safe storage of medications and disposal/destruction of refused or contaminated medications. Going forward the Pharmacy will continue to monitor medication storage and administration; any findings will be corrected upon discovery. Staff Educator/Designee conducted an in-service/education to all licensed nursing staff to ensure that Midodrine is administered as per the parameters ordered by the physician. Education was completed on 01/01/2023. **4. MONITORING CORRECTIVE ACTION** Unit Managers will audit their respective units for accuracy of medication administration and storage. This audit will be done weekly for four (4) weeks and monthly for three (3) months. Findings to be reported to the monthly QAPI for further recommendations. All negative findings will be corrected upon discovery. Unit Managers/Designee will conduct a house wide audit of all the residents receiving Midodrine medication to ensure the parameters are followed as per the Physician's orders. This audit will be completed weekly for four (4) weeks and monthly for three (3) months. Findings to be reported to the monthly QAPI for further recommendations. Date of Compliance: 01/09/2023	

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 _____	R-C 12/15/2022

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 6	{L 052}		

#10 during the medication observation, she acknowledged leaving the unlabeled medication cup containing a resident's medications unattended on the medication cart. She was asked why the opened, unlabeled medications were left unattended on the cart. She stated, "These were for [Resident #158], she refused her medications...I will go back to give them to her."

The Writer went to Resident #158's room. She was observed in her room asleep without any noted distress.

The Writer returned to the medication cart and asked Employee #10, What medications were in the unlabeled medication cup. She stated, "Depakote (used to treat Seizures, Bipolar), Finasteride (used to treat Benign Prostatic Hyperplasia in men), Nifedipine (used to treat High Blood Pressure) and Ferrous Sulfate (used to treat Iron Deficiency Anemia)."

There was no evidence that Employee #10 secured the medications in the souffle cup, they were not under direct observation of authorized staff, thus leaving the medication accessible to residents.

In addition, a review of the Medication Administration Record (MAR) on 12/14/2022 at approximately 2:35PM revealed Resident #158, did not have physician orders to receive Depakote, Finasteride, Nifedipine, or Ferrous Sulfate.

During a face-to-face interview with Employee #10 and Employee #2 DON (Director or Nursing) at approximately 2:54PM, the Writer asked Employee #10 if she knew who the unattended medications belonged to? She stated, "[Resident

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 _____	R-C 12/15/2022

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 7 #158]." Writer informed Employee #10 and Employee #2 that Resident #158's MAR was reviewed, and it was found that those medications were not ordered for her. Employee #10 stated, "I don't know how I got it mixed up." The Surveyor then asked the Employee #10 what happened to the medications that were unlabeled on the cart that you said belonged to Resident #158? Employee #10 stated, "I threw them away ... another Nurse gave her [Resident #158] meds when she woke up ..." 3. Facility staff failed to ensure that one (1) resident received sufficient nursing time to provide treatment and care in accordance with professional standards of practice as evidence by failure to assess/reassess Resident #9's elevated blood pressure in a timely manner. Resident #9 was admitted to the facility on 11/13/2021 with diagnoses that included Hypertension, Dementia, Muscle Weakness and Anemia. Annual Minimum Data Set (MDS) dated 10/21/22 showed facility staff coded intact cognition. During a medication observation on Unit 4 North on 12/14/22 at approximately 10:26AM, a vital sign sheet was observed on a medication cart that listed Resident #9's name and his blood pressure reading of 149/104 (normal range is 120/80) for that morning. Employee #8 (Registered Nurse, RN) was passing medication to another resident from the same medication cart during the time of the observation. Review of Resident #9's medical record showed, a physician's order, dated 03/29/22, "Norvasc (treats high blood pressure) Tablet 5 (MG)	{L 052}		

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 _____	R-C 12/15/2022

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 8 Milligrams ... Give 1 tablet by mouth one time a day for Hypertension ..." 12/08/22 [physician's order] "Clonidine Patch Weekly 0.1MG/HR (hour) ... Apply 1 patch transdermally every Thu [Thursday] for High blood pressure." A face-to-face interview was conducted with Resident #9 on 12/14/2022 at approximately 10:28 AM. During this time, He was observed seated in a wheelchair wheeling himself into his room. He stated he was feeling fine, he wanted to know if the Writer and another State Surveyor were from the bank, he shared that he worked with the Senate and he continue to roll himself into his room. Review of the resident's record was conducted on 12/14/22 at approximately 2:45PM, this revealed that Employee #8 entered the residents blood pressure as149/97 at 2:38PM. Review of the progress notes showed there was no mention of the blood pressure reading 149/104 for that day, nor was it recorded in the vital sign section of the clinical record. During a face-to-face interview with Employee #8 on 12/14/22 at approximately 3:07PM, she was asked why she did not follow up on Resident #9's blood pressure reading when she was given and acknowledged Resident #9's blood pressure reading at 07:30AM, she stated, "I was passing my meds and was going to get to him." She was then asked about the blood pressure reading that was entered in the resident's record at 2:38PM. She stated, "I'm not the one who entered it." When asked again why she did not follow up with the elevated blood pressure reading, she stated "I	{L 052}		

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 _____	R-C 12/15/2022

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 9	{L 052}		

was busy with another resident who I had to transfer out ... I checked on him [Resident #9] and removed his patch." It should be noted that the date of this interview was Wednesday, 12/14/22 and the Physician Medication Order states "Apply 1 patch transdermally every Thu [Thursday] for High blood pressure." Additionally, there are no orders to indicate that the patch should be removed on Wednesday. When asked why she took off his Clonidine Patch, she stated "I don't know."

It should be noted that there was no evidence that Resident #9 suffered any untoward outcome.

4. Facility staff failed to ensure that Resident #4 was administered his blood pressure medications in accordance with the physician's order.

Resident #4 was readmitted to the facility on 10/11/2022 with multiple diagnoses that included: Hypotension, CHF (Congestive Heart Failure), Hypertensive Heart Disease, and End Stage Renal Disease.

Review of Resident #4's medical record revealed the following:

10/28/2022 [physician's order] "Midodrine (for low blood pressure) HCl (Hydrochloride) Tablet 5 MG (milligrams), give 3 tablets by mouth 1 time a day every Mon (Monday), Tue (Tuesday), Wed (Wednesday), Thu (Thursday), Fri (Friday), Sat (Saturday), Sun (Sunday) for low blood pressure hold if BP (blood pressure) IS > (greater than) 130"

Review of the Medication Administration Record (MAR) for December 2022 showed that on the following dates the resident was given Midodrine

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 _____	R-C 12/15/2022

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 10 5 MG outside of the directed parameters for administration: 12/10/2022 at 01:02 AM - BP 134/79 12/10/2022 at 11:12 PM - BP 134/76 12/11/2022 at 02:58 PM- BP 134/88 12/12/2022 at 11:57 AM -BP 138/67 It should be noted that the medication was scheduled to be administered at 9:00 am daily. According to the clinical record there were no blood pressure measurements taken at the time (09:00 AM) the nurses signed that Midodrine was administered to the resident. During a face-to-face interview conducted on 12/15/2022 at 1:17 PM, Employee #2 (Director of Nursing) reviewed the documentation and acknowledged the findings. 5. Facility staff failed to ensure that Resident #189 was administered his blood pressure medications in accordance with the physician's order. Resident #189 was readmitted on 10/05/2022 with multiple diagnoses that included: Orthostatic Hypotension, Hypotension, Hypertension, Hypertensive Chronic Kidney Disease, and End Stage Renal Disease. Review of Resident #189's medical record revealed the following: 10/08/2022 [physician's order] "Midodrine Tab 5MG (milligrams) Give 1 tablet orally three times a day every Tue (Tuesday), Thu (Thursday), Sat (Saturday) related to Essential (Primary) Hypertension Hold if SBP (systolic blood pressure) > (greater than) 120MG/DL (milligrams	{L 052}		

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 _____	R-C 12/15/2022

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 11 per deciliter)" Review of the Medication Administration Record (MAR) for December 2022, showed that on the following dates, Resident #189 was given Midodrine 5MG outside of the directed parameters for administration: 12/08/2022 at 12:29AM - BP 127/74 12/08/2022 at 04:10PM - BP 124/69 12/08/2022 at 07:01PM - BP 127/66 12/10/2022 at 12:52AM - BP 138/80 12/10/2022 at 05:08PM - BP 132/69 12/10/2022 at 10:55PM - BP 128/70 12/13/2022 at 12:52AM - BP 134/79 12/13/2022 at 11:36AM - BP 125/66 It should be noted that the medication was scheduled to be administered at 08:00AM, 02:00 PM and 10:00 PM every Tuesday, Thursday, and Saturday. According to the clinical record, there were no blood pressure measurements taken at the time (08:00 AM, 02:00 PM, 10:00 PM) the nurses signed that Midodrine was administered to the resident. During face-to-face interview conducted on 12/15/2022 at 1:17 PM, Employee #2 (Director of Nursing) reviewed the documentation and acknowledged the findings.	{L 052}		
{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	{L 128}	L128 **1. CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** A head-to-toe assessment was done by the licensed nurse for Resident#10 on 12.20.22, Resident#15 on 12.21.22, Resident#110 on 12.22.22 and they suffered no negative outcome from this delay. Employee #5 and Employee #6 were educated on 1/6/23 safely storing, logging in the narcotic log and documenting receipt of narcotics from the pharmacy. The licensed staff responsible completed a late entry to rectify the deficiency.	

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 _____	R-C 12/15/2022

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 12 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; (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 observations, record reviews and staff interviews, for three (3) of 30 sampled residents and for two (2) of eight (8) nursing units, facility staff failed to account for the receipt, usage, administration, and reconciliation of controlled medications. Residents' #110, #10 and #15. The findings included: Review of the facility's Plan of Correction with a compliance date of 12/05/22 documented," ...will conduct in-service for licensed nurses on the policy to ensure accurate narcotic counts are reconciled per the standards of practice ...ADON (Assistant Director of Nursing) or designee will conduct house wide audits of all narcotic counts and will audit the narcotic count log book to ensure narcotic count matches the logs weekly for four weeks ..."	{L 128}	**2. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** A house-wide audit was completed by Unit Managers on 12/17/22 for all medication carts to ensure Narcotics received are signed for, logged in correctly. This audit was completed on 12/17/22. Any negative findings were corrected upon discovery. **3. MEASURE TO PREVENT REOCURRENCE** Education was completed for all licensed nurses by the Staff educator/designee on 1/1/23 for logging in new narcotics received by the pharmacy and ensuring they sign for it on receipt. Education included ensuring appropriate narcotic counts at the start and end of the shift with appropriate documentation on administration of narcotics. Going forward pharmacy will continue to monitor medication storage and narcotic logs on a monthly and report any negative findings. **4. MONITORING CORRECTIVE ACTION** Unit Managers will audit their respective units to ensure narcotics received by the pharmacy are properly signed for, logged and documented in the narcotic count sheet. This audit will be done weekly for four (4) weeks and monthly for three (3) months. Findings to be reported to the monthly QAPI for further recommendations. All negative findings will be corrected upon discovery. Date of Compliance: 01/09/2023	

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 _____	R-C 12/15/2022

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 13 1. Facility staff failed to account for the amount of Clonazepam (medication used to prevent and treat seizures, panic and anxiety disorders) tablets received for Resident #110. During a narcotic count on 12/14/22 at 11:23 AM on unit 1 north with Employee #5 (Registered Nurse/RN), a blister pack containing 30 tablets of Clonazepam 1mg (milligrams) was observed for Resident #110. The "Controlled Drug Administration Record ..." form that recorded the receipt of Resident #110's Clonazepam 1mg tablets documented, "date received 12/05/22" but failed to document, "amount received" or "signature" of the staff who received the medication. At the time of the finding, Employee #5 was asked how she ensured that the amount of Clonazepam 1mg tablets being counted is what was received by the pharmacy on 12/05/22, she stated, "I am not sure who received the medication. We've just been counting what is in the [narcotic] box." Resident #110 was admitted to the facility on 12/10/19 with diagnoses that included: Seizures, Anxiety Disorder and Schizophrenia. Review of Resident #110's medical record revealed: 07/14/22 [physician's order] "Clonazepam Tablet 1 mg Give 1 tablet by mouth three times a day related to Anxiety Disorder" The evidence showed that from 12/05/22 to 12/14/22, a total of 10 days, facility staff failed to account for the receipt and reconciliation of	{L 128}		

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 _____	R-C 12/15/2022

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 14 Resident #110's controlled medication, Clonazepam 1 mg tablets. 2. Facility staff failed to account for the usage, disposition, administration, and reconciliation of Resident #10's Pregabalin (medication used to treat epilepsy and neuropathic pain) and Resident #15's Tramadol (narcotic pain medication). Resident #15 was admitted to the facility on 09/19/22 with diagnoses that included: Pain, Liver Cell Carcinoma and Acute Kidney Failure. A. During a narcotic count on unit 2 north on 12/14/22 at 11:32 AM with Employee #6 (Licensed Practical Nurse/LPN), the "Controlled Drug Administration Record ..." form for Resident #10's Pregabalin 300 mg tablets showed, " ...date/time 12/10/22 9 AM; dose administered 1 tab (tablet) ... admin (administered) by [Nurse signature] amount rem (remaining) 15", followed by a blank entry line then, " ...date 12/11/22 7 PM; dose administered 1 tab ... admin by [Nurse signature] amount rem 13". There was no documented evidence to show the date, time or signature of the licensed staff who took out the 14th dose of Resident #10's Pregabalin 300 mg tablet. During a face-to-face interview conducted at the time of the observation, Employee #6 stated, "I am not sure why there's a space on the form, I'll have to check with my unit manager." Review of Resident #10's medical record showed: 11/17/22 [physician's order] "Pregabalin Capsule	{L 128}		

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 _____	R-C 12/15/2022

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 15 300 MG Give 1 capsule by mouth two times a day for pain" Medication Administration Record (MAR) for December 2022 showed that on 12/10/22 at 7:00 PM, a licensed staff documented a check mark and their initials to indicate that Pregabalin Capsule 300 MG was administered to Resident #10. The evidence showed that from 12/10/22 to 12/14/22, a total of 5 days, facility staff to to account for the usage, administration, and reconciliation of Resident #10's Pregabalin 300 mg capsules. B. During a narcotic count on unit 2 north on 12/14/22 at 11:32 AM with Employee #6, the "Controlled Drug Administration Record ..." form for Resident #15's Tramadol 50 MG tablets showed, that on 12/12/22 [at] 2 PM, dose administered 1 tab(tablet) ... admin by [Nurse signature] amount rem (remaining) 29". The next line showed, "amount rem 28", (indicating that a dose was removed by facility staff); however, there was no documented date/time, dosage amount or signature of who removed the medication. During a face-to-face interview conducted at the time of the observation, Employee #6 stated that he can't explain why Resident #15's "Controlled Drug Administration Record ..." form for Tramadol 50 MG was missing that vital information. The employee was further asked if he had noted this discrepancy when he conducted the narcotic reconciliation count at the start of his shift, Employee #6 stated, "I'll have to bring this to my unit manager."	{L 128}		

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 _____	R-C 12/15/2022

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 16 Review of Resident #15's medical record showed: 12/05/22 [physician's order] "Tramadol Tablet 50 MG Give 1 tablet by mouth every 6 hours as needed for pain". On 12/09/2022 the medication was discontinued by the physician at 6:02 PM. Review of the December MAR showed that from 12/01/22 to 12/15/22, Resident #15 did not receive Tramadol 50 MG. It should be noted that, Resident #15's December 2022 MAR shows that Tramadol 50 mg was not administered. The Controlled Drug Administration Record showed that Tramadol was removed for the packing on 12/12/22 at 2:00 PM (3 days after it was discontinued) and from 12/12/22 to the date of this observation, another tablet of Tramadol 50 MG was removed from the packaging. During a face-to-face interview conducted on 12/15/22 at 2:20 PM with Employees #2 (Director of Nursing/DON) and #7 (Staff Educator), Employee #7 stated that no issues were found during their audits of the narcotic books/count that have been done so far. Both employees reviewed the "Controlled Drug Administration Record ..." forms for Residents' #110, #10 and #15 and made no further comments.	{L 128}	L201	
L 201	3231.12 Nursing Facilities Each medical record shall include the following information:	L 201	**1. CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** The note for resident #2 was corrected with clarification of time of the visit. The resident suffered no negative outcome.	

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 _____	R-C 12/15/2022

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 201	Continued From page 17 (a)The resident's name,age, sex, date of birth, race, martial status home address, telephone number, and religion; (b)Full name, addresses and telephone numbers of the personal physician, dentist and interested family member or sponsor; (c)Medicaid, Medicare and health insurance numbers; (d)Social security and other entitlement numbers; (e)Date of admission, results of pre-admission screening, admitting diagnoses, and final diagnoses; (f)Date of discharge, and condition on discharge; (g)Hospital discharge summaries or a transfer form from the attending physician; (h)Medical history and allergies; (i)Descriptions of physical examination, diagnosis and prognosis; (j)Rehabilitation potential; (k)Vaccine history, if applicable, and other pertinent information about immune status in relation to vaccine preventable disease; (l)Current status of resident's condition; (m)Physician progress notes which shall be written at the time of observation to describe significant changes in the resident's condition, when medication or treatment orders are	L 201	**2. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** All residents visited by the Psychiatric practitioner in question have the potential to be affected by this practice. An audit was completed on 12/24/22 to ensure that all notes entered since November 2022 by the Psychiatric practitioner were documented for the time of the visit when the resident was in-house. There were no further negative findings. **3. MEASURE TO PREVENT REOCURRENCE** 1:1 education was done for the Psychiatrist by the Staff educator/designee on 12/16/22 to ensure safe documentation practices. **4. MONITORING CORRECTIVE ACTION** An audit will be done by the Unit Managers/designee to ensure that the notes entered by the Psychiatric practitioner reflect the time of the visit and ensure resident is present in house at the time of the visit. This audit will be done weekly for four (4) weeks, monthly for three (3) months. Findings will be brought to QAPI monthly for recommendations and review. All negative findings will be addressed upon discovery. Date of Compliance 01/09/2023.	

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 _____	R-C 12/15/2022

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 201	Continued From page 18 changed or renewed or when the resident's condition remains stable to indicate a status quo condition; (n)The resident's medical experience upon discharge, which shall be summarized by the attending physician and shall include final diagnoses, course of treatment in the facility, essential information of illness, medications on discharge and location to which the resident was discharged; (o)Nurse's notes which shall be kept in accordance with the resident's medical assessment and the policies of the nursing service; (p)A record of the resident's assessment and ongoing reports of physical therapy, occupational therapy, speech therapy, podiatry, dental, therapeutic recreation, dietary, and social services; (q)The plan of care; (r)Consent forms and advance directives; and (s)A current inventory of the resident's personal clothing, belongings and valuables. This Statute is not met as evidenced by: Based on record review and staff interview, for one (1) of 30 sampled residents, the psychiatric physician failed to document a progress note that was written at the time of observation. Resident #2. The findings included:	L 201		

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 _____	R-C 12/15/2022

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 201	Continued From page 19 Resident #2 was admitted to the facility on 03/10/21 with multiple diagnoses that included: Psychoactive Substance Abuse, Chronic Obstructive Pulmonary Disease and Abnormalities of Gait and Mobility. Review of Resident #2's medical record revealed: Quarterly Minimum Data Set (MDS) dated 09/17/22 showed facility staff coded: intact cognition. 11/24/22 [physician's order] "Resident may go LOA (leave of absence)" 11/24/22 at 11:32 AM "Nurses Note ... Resident ... out LOA with family member at 10:40am ...she will be return tomorrow on 11/25/22 ..." 11/25/22 at 2:24 PM "Physicians Progress Note Late Entry ... Physician follow-up Psychiatric Evaluation. Date of visit: 11/25/22. Subjective ...Reports mood as "good" and cites poor sleep and fatigue, but with improvement ... Appearance: Fairly groomed in street clothes, no apparent psychomotor agitation or depression. Orientation: Oriented to place, person, date ..." 11/25/22 at 10:48 PM "Nurses Note ...Resident returned from LOA (leave of absence) at 9:02pm ....Resident ambulates to and from courtyard at this time with no distress noted ..." The evidence showed that per the facility's documentation, Resident #2 was on LOA and out of the facility from 11/24/22 at approximately 10:40 AM until 11/25/22 at approximately 9:05 PM. However, on 11/25/22 at 2: 24 PM, the psychiatric physician documented to completing a	L 201		

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 _____	R-C 12/15/2022

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 201	Continued From page 20 follow-up evaluation on the resident. During a face-to-face interview conducted on 12/15/22 at 2:20 PM, Employee #2 (Director of Nursing/DON) reviewed the progress note, acknowledged the finding and made no further comment.	L 201		
{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 and staff interview, for one (1) of 30 sampled residents, facility staff failed to investigate an unusual incident in which a resident was found unresponsive in the facility's courtyard. Resident #2. The findings included: Review of the facility's Plan of Correction with a compliance date of 12/05/22 documented, "...will in-service all staff and leadership on the Abuse	{L 204}	L204 **1. CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** The investigation for the incident for Resident #2 was completed on 12.30.22 and statements were obtained from the applicable employees. The information obtained through the investigation did not have any impact on the resident's condition. A head-to-toe assessment was done by the licensed nurse on 12.21.22 and the resident suffered no negative outcome from this delay. **2. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** All residents have the potential to be affected. LNHA/ Designee conducted a house wide audit on 12/21/22 of all incidents from 11/25/22 to 12/21/22 to ensure that all incidents that meet Federal and State reporting criteria have been reported to the DOH in a timely manner and investigated thoroughly.	

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 _____	R-C 12/15/2022

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 204}	Continued From page 21 Policy and procedure to ensure the facility implements its policy on properly investigating any unusual incident ..." Resident #2 was admitted to the facility on 03/10/21 with multiple diagnoses that included: Psychoactive Substance Abuse, Chronic Obstructive Pulmonary Disease and Abnormalities of Gait and Mobility. Review of Resident #2's medical record revealed: Quarterly Minimum Data Set (MDS) dated 09/17/22 showed facility staff coded: intact cognition; independent for locomotion off the unit; no functional impairment in range of motion; and did not use any mobility devices. 11/25/22 at 11:02 PM "Nurses Note ...At 10.05pm resident was observed to be unresponsive to verbal and tactile stimulation on her wheelchair at the courtyard. However, there was presence of pulse and breathing. Resident was wheeled to her room and placed on her bed ...Resident was placed on 15 liters oxygen via nonrebreather mask ... [Doctor] was notified and order was given to give resident 0.4 mg /ml (milligrams/milliliters) of Naloxone (medicine that rapidly reverses an opioid overdose). Resident became verbally responsive on administration of the first dose ..." A Facility Reported Incident (FRI) received by the state agency on 12/07/22 documented, "Submitted On: Dec 6, 2022, 06:36PM EST (Eastern Standard Time) ... Per charge nurse, resident returned from LOA (leave of absence) at about 9 pm on 11/25/2022 in a stable condition. At 10:05pm, resident was observed to be unresponsive to verbal and tactile stimulation on	{L 204}	**3. MEASURE TO PREVENT REOCURRENCE** Education was completed for the Inter Disciplinary Team and clinical staff responsible for incident reporting and investigations This education was completed on 12.31.22 by Staff Educator/designee to ensure every incident that meets Federal and State reporting criteria have been reported to the DOH in a timely manner and has an appropriate investigation, with statements as applicable to the incident. Going forward all incidents will be reviewed by the DON and Administrator prior to its conclusion **4. MONITORING CORRECTIVE ACTION:** LNHA/ Designee will conduct an audit of incident report forms, weekly for four (4) weeks and monthly for three (3) months to ensure incidents reported timely and are thoroughly investigated. Results of finding will be forward to QAPI for review and recommendations. Date of Compliance: 01/09/2023	

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 _____	R-C 12/15/2022

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 204}	Continued From page 22 her wheelchair in the courtyard. However, there was presence of pulse and breathing. Resident was escorted to her room in wheelchair and placed on her bed. Resident was assessed ...Resident was placed on 15 liters oxygen via non rebreather mask ...[Doctor] was notified and ordered 0.4 mg /ml of Naloxone. Resident became verbally responsive on administration of the first dose. She could not verbalize what happened. MD (medical doctor) was made aware of resident's response and ordered to monitor resident 's vital signs every 2 hours x 2 days and notify MD of any abnormalities ..." Review of the facility's FRI binder and packet for this unusual incident showed no documented evidence that an investigation was conducted. There were no statements from the staff who first observed Resident #2 "unresponsive to verbal and tactile stimulation"; no statement from any of the three courtyard monitors on shift at the time of the incident; and no statement from any other residents who were present in the courtyard at the time of the incident. During a face-to-face interview conducted on 12/15/22 at 2:20 PM, Employee #1 (Administrator) stated, "All incidents are reviewed by the Administrator, Director of Nursing (DON) and QA (Quality Assurance) for interviews and completeness before going to DOH (Department of Health)." When asked why there was no documented evidence that an investigation was done for Resident #2's unusual incident, Employee #1 made no comment.	{L 204}	L206 **1. CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** The incident was reported on 12.6.22. The delay in reporting did not have any impact on the resident's condition. A head-to-toe assessment was done by the licensed nurse on 12.21.22 and the resident suffered no negative outcome from this delay.	
{L 206}	3232.4 Nursing Facilities Each incident shall be documented in the	{L 206}		

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 _____	R-C 12/15/2022

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 206}	Continued From page 23 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 occurrence. This Statute is not met as evidenced by: Based on record review and staff interview, for one (1) of 30 sampled residents, facility staff failed to report an unusual incident where one resident was found unresponsive in the facility's courtyard to the State Agency in a timely manner. Resident #2. The findings included: Review of the facility's Plan of Correction with a compliance date of 12/05/22 documented, "...will in-service all staff and leadership to ensure the facility implements ... reporting of unusual incidents to the appropriate law enforcement entity in a timely manner ... will conduct an audit of incident reports forms ... weekly for four weeks ..." Resident #2 was admitted to the facility on 03/10/21 with multiple diagnoses that included: Psychoactive Substance Abuse, Chronic Obstructive Pulmonary Disease and Abnormalities of Gait and Mobility. Review of Resident #2's medical record revealed: Quarterly Minimum Data Set (MDS) dated 09/17/22 showed facility staff coded: intact cognition; independent for locomotion off the unit; no functional impairment in range of motion; and did not use any mobility devices. 11/25/22 at 10:48 PM "Nurses Note ...Resident	{L 206}	**2. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** All residents have the potential to be affected. LNHA/ Designee conducted a house wide audit on 12/21/22 of all incidents from 11/25/22 to 12/21/22 to ensure that all incidents that meet Federal and State reporting criteria have been reported to the DOH in a timely manner and investigated thoroughly. **3. MEASURE TO PREVENT REOCURRENCE** Education was completed for the Inter Disciplinary Team and clinical staff responsible for incident reporting and investigations This education was completed on 12.31.22 by Staff Educator/designee to ensure every incident that meets Federal and State reporting criteria have been reported to the DOH in a timely manner and has an appropriate investigation, with statements as applicable to the incident. Going forward all incidents will be reviewed by the DON and Administrator prior to its conclusion. **4. MONITORING CORRECTIVE ACTION:** LNHA/ Designee will conduct an audit of incident report forms, weekly for four (4) weeks and monthly for three (3) months to ensure incidents reported timely and are thoroughly investigated. Results of finding will be forward to QAPI for review and recommendations. Date of Compliance: 01/09/2023	

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 _____	R-C 12/15/2022

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 206}	Continued From page 24 returned from LOA (leave of absence) at 9:02pm...Resident ambulates to and from courtyard at this time with no distress noted ..." 11/25/22 at 11:02 PM "Nurses Note ...At 10:05pm resident was observed to be unresponsive to verbal and tactile stimulation on her wheelchair at the court yard. However there was presence of pulse and breathing. Resident was wheeled to her room and placed on her bed ...Resident was placed on 15 liters oxygen via non rebreather mask ... [Doctor] was notified and order was given to give resident 0.4 mg /ml (milligrams/milliliters) of Naloxone (medicine that rapidly reverses an opioid overdose). Resident became verbally responsive on administration of the first dose ..." A Facility Reported Incident (FRI) received by the state agency on 12/07/22 documented, "Submitted On: Dec 6, 2022, 06:36 PM EST (Eastern Standard Time) ... Per charge nurse, resident returned from LOA at about 9 pm on 11/25/2022 in a stable condition. At 10:05pm, resident was observed to be unresponsive to verbal and tactile stimulation on her wheelchair in the court yard. However, there was presence of pulse and breathing. Resident was escorted to her room in wheelchair and placed on her bed. Resident was assessed ...Resident was placed on 15 liters oxygen via non rebreather mask ... [Doctor] was notified and ordered 0.4 mg /ml of Naloxone. Resident became verbally responsive on administration of the first dose. She could not verbalize what happened. MD (medical doctor) was made aware of resident's response and ordered to monitor resident 's vital signs every 2 hours x 2 days and notify MD of any abnormalities..."	{L 206}		

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 _____	R-C 12/15/2022

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 206}	Continued From page 25 The evidence showed that this unusual incident occurred on 11/25/22; however, the facility did report this incident to the State Agency until 12/06/22, 11 days later. During a face-to-face interview conducted on 12/15/22 at 2:20 PM, Employees #1 (Administrator) and #2 (Director of Nursing/DON) were asked why Resident #2's unusual incident was not submitted timely to the State Agency. The employee's acknowledged the finding and made no comments.	{L 206}		
{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 and staff interview, for one (1) of 30 sampled residents, facility staff failed to ensure that one resident was provided privacy during ADL (activities of daily living) care. Resident #1. The findings included: Review of the facility's Plan of Correction with a compliance date of 12/05/22 documented, "...will provide an in-service [to] all staff on resident rights including maintaining privacy and dignity ...During grand rounds, staff will conduct a house wide audit to ensure that resident privacy and dignity are maintained during care ..." Resident #1 was admitted to the facility on 09/03/22 with multiple diagnoses that included: Dementia, Glaucoma and Muscle Weakness.	{L 521}	**L521** **1. CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** Resident#1 was assessed by the Licensed nurse on 12/21/22 and ensured that the resident's privacy and dignity are maintained. Resident suffered no negative outcomes. Employee #3 was educated on 1/7/23 on importance of maintaining Resident rights, dignity, and privacy. **2. IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED:** A one-time house wide audit was completed on 12/19/22 by the (SW and IDT) to ensure residents rights, dignity and privacy were maintained. No other residents were affected	

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 _____	R-C 12/15/2022

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 521}	Continued From page 26 A Quarterly Minimum Data Set (MDS) dated 12/08/22 showed facility staff coded: moderately impaired cognition and required extensive assistance with one-person physical assist for personal hygiene. During a tour of unit 1 south on 12/14/22 at 10:36 AM, the following was observed from the hallway as the surveyor walked by room 117: Resident #1 was lying in bed with his incontinence brief exposed to anyone walking by the room, as Employee #3 (Certified Nurse Aide/CNA) was giving him a bed bath. The privacy curtain was not pulled, and the door was open. During a face-to-face interview conducted at the time of the observation, Employee #3 was asked why she did not pull the curtain to ensure that Resident #1 was provided with privacy, the employee stated, "I just started to get him washed and was helping his roommate too." It should be noted that Employee #3 signed her name to attest that she received the facility's in-service training on "Resident Rights" that was conducted on 10/07/22.	{L 521}	**3. MEASURE TO PREVENT REOCURRENCE:** Education was completed by Staff Educator/ designee for all IDT and for all staff on 01/09/23 to ensure that resident rights, dignity and privacy are maintained. **4. MONITORING CORRECTIVE ACTION:** Social Work Directors or designee will audit one floor (north and south units) per week to ensure that resident's privacy and dignity are maintained. This audit will be completed weekly times four (4) and monthly times three (3). Negative findings will be corrected upon discovery. All findings to be reported to the monthly QAPI for further recommendations. Date of Compliance: 01/09/2023	