STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095036	A. Building B. Wing	11/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Unique Rehabilitation and Health Center LLC	901 First Street NW Washington, DC 20001

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and staff interview for four (4) of 75 sampled residents, facility staff failed to provide a comfortable, sanitary, homelike environment to four (4) residents, as evidenced by two (2) resident's rooms with dirty floors covered with debris and a sticky-like substance, including multiple wheelchair tire tracks, two (2) resident's rooms with flies, two (2) resident's rooms with a clutter of boxes, bins and other unboxed items piled against the wall and around the resident's bed, two (2) resident's rooms without bed linens on their bed, one (1) resident with a foul odor of urine beginning at the doorway, and one(1) resident with a dirty sticky floor and a foul odor in the room. Residents #76, #7,#103 and #115. The findings included: 1. Resident #76 was admitted to the facility on [DATE] with multiple diagnoses that included: Hemiplegia and Hemiparesis following Cerebral Infarction affecting Left Dominant Side, Atherosclerosis of Native Arteries of Other Extremities with Ulceration, Peripheral Vascular Disease, and Muscle Wasting and Atrophy. A review of Resident #76's medical record revealed a Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented: facility staff coded a Brief Interview for Mental Status (BIMS) summary score of '15,' indicating the resident was cognitively intact. Functional Abilities and Goals that documented: totally dependent on staff for chair/bed-to-chair transfer; required Substantial/Maximal assistance with personal hygiene, toileting, bathing and dressing; used a motorized wheelchair for locomotion on/off the unit. During an observation conducted on 11/04/24 at 12:20 PM Resident #76's room was noted to be cluttered with personal belongings creating a trip hazard, including food and clothing piled up in a corner and on the resident's bare mattress. There were no bed linens on the resident's bed, the floor was littered with debris and food crumbs, and there was a fly observed flying around the room during the observation. During a face-to-face interview conducted with Resident #76 he stated, There's an issue with getting clean linen every day for my bed and no one asked to help clean my room. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #7 was admitted to the facility on [DATE] with multiple diagnoses that included: Dementia, Hemiplegia and Hemiparesis following Other Cerebrovascular Accident affecting Right Non-Dominant Side, Speech and Language Deficits following Unspecified Cerebrovascular Accident, and Muscle Wasting and Atrophy. A review of Resident #7's medical record revealed a Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented: facility staff coded a Brief Interview for Mental Status (BIMS) summary score of '09,' indicating the resident was moderately impaired. Functional Abilities and Goals that documented: Substantial/maximal assistance from staff with toileting, personal hygiene, bathing, dressing and Partial/moderate assistance from staff with chair/bed-to-chair transfer; used a manual wheelchair for locomotion on/off unit. During an observation conducted on 11/04/24 at 12:30 PM Resident #7's room was noted to have a foul odor of urine beginning at the doorway and inside of the resident's room. There were several flies in the room and concentrated on and around the resident's bed and the floor was dirty with an unknown sticky substance covering part of the floor. 3. Resident #103 was admitted to the facility on [DATE] with multiple diagnoses that included Human Immunodeficiency Virus (HIV) Disease, Chronic Obstructive Pulmonary Disease (COPD), and Cerebrovascular Accident (CVA) with right sided weakness. A review of Resident #103's medical record revealed a Quarterly Minimum Data Set (MDS) assessment dated [DATE] that documented: facility staff coded a Brief Interview for Mental Status (BIMS) summary score of '15,' indicating the resident was cognitively intact. Functional Abilities and Goals that documented: one-person physical assist with bed mobility, transfers, eating and toilet use; limited range of motion/impairment on one side to upper and lower extremities, and used a motorized wheelchair for locomotion on/off the unit. During an observation conducted on 11/04/24 at 12:45 AM Resident #103's room was noted to have a dirty floor with an unknown sticky-like substance and wheelchair tire marks. The mattress was bare, without clean bed linens. The area surrounding the resident's bed was cluttered with personal belongings creating a tripping hazard, including storage bins, cardboard boxes and other unboxed items piled against the wall. During a face-to-face interview conducted on 11/04/24 at approximately 1:00 PM Employee #14 (RN) acknowledged the findings and stated, We ran out of linens, just waiting to see when we will get some more. Will have to check with the resident to see when it's a good time to clean the room. Cross Reference 22B DCMR § 3256.1 4. Resident #163 was admitted to the facility on [DATE] with diagnoses that included: Dislocated Right Hip Arthroplasty, Cervical Spinal Stenosis, Osteomyelitis, Dependence on a Wheelchair, Psychoactive Substance Use, Alcohol Abuse, Type 2 Diabetes Mellitus, Tobacco Use, and Moderate Adjustment Disorder with Mixed Anxiety and Depressed Mood. A review of Resident #163's medical record revealed a Face Sheet which showed that Resident #163 was the responsible party. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #163's Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented that the resident had a BIMS score of 14, indicating intact cognition. During an initial tour of Unit # 3 North on 11/06/24 at 10:31 AM, Resident #163's room was observed with a sticky, dirt-stained floor and a foul-smelling odor in the Resident #163's room. The Resident was not in his room at the time of the observation. The Resident's bed (Bed A) was unmade with the bed linens, drawn back in disarray and a personal blanket partially on the bed and on the floor at the foot of the Resident's bed. Piled in the center of the Resident's bed mattress were the resident s belongings including his wallet and single dollar bills. On the floor at the foot of the Resident's bed, were two (2) large, clear trash bags with the Resident's belongings in them. Next to the resident's bed on the floor was an empty urinal. The Resident's roommate who was nonverbal, was asleep in Bed B. During a face-to-face interview with Employee #29/Certified Nurse Aide (CNA), said she was not aware of the condition of the Resident's room, because she was not assigned to the resident. She then added that she would let the Unit Manager know that the Resident's room needed to be cleaned. At approximately 11:30 AM on 11/06/24, Resident #163's room was observed in the same condition and the Resident was not in the room. During a face-to-face interview with Employee #28/3 North Unit Manager,(Registered Nurse), on 11/06/24 at approximately 11:30 AM, she acknowledged that the floor was dirty, and there was an odor in the resident's room. She stated that the Resident had spilled the urinal on the floor, and he would not allow EVS (environmental services) staff to come in and clean the room while he was there. She then stated that she was unaware that the Resident had left his room. She then asked EVS to clean the Resident's room. When asked if the room was cleaned daily, she stated that it was, and added that she would have EVS clean the Resident's room. Cross Reference 22B DCMR § 3256.1

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and staff interviews, for one (1) out of 75 sampled residents, facility staff failed to ensure that they took the steps to investigate Resident #56's grievance that an aide handled him roughly during ADL care. The findings included: Review of the facility's Grievance Policy (not dated) documented: - This policy ensures acknowledgement of grievance procedures and fair and timely resolution of grievances. - Grievances can include behavior of staff, care and treatment provided by the staff or other concerns regarding their long-term or short-term stay. - The facility has 72 hours to investigate and resolve the grievance. - The following grievances are reported to Department of Health (DOH) - abuse and neglect. - The facility must ensure that all written grievance decisions include steps taken to investigate the grievance, a summary of pertinent findings or conclusions regarding the residents' concerns, a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken by the facility. Resident #56 was admitted to the facility on [DATE] with multiple diagnoses that included: Chronic Respiratory Failure, Malignant Neoplasm of Lower Gum and Mouth, and Dysphagia. Review of the resident's medical record revealed the following a modified admission Minimum Data Set (MDS) assessment dated [DATE] showed that facility staff coded: no speech; makes self-understood; able to understand others; a Brief Interview for Mental Status (BIMS) summary score of 14, indicating intact cognitive response; no potential indicators of psychosis; no behavioral symptoms; had functional impairment on one side for upper and lower extremities; and required substantial/maximal assistance for toileting hygiene and personal hygiene. A Resident - Family Complaint Form (facility's grievance form) dated 07/15/24 documented: - [Resident #56] is the person initiating the report. - Date of incident: 07/15/24; date report completed 07/15/24. - Name of person receiving complaint: Employee #18 (Unit 2 north/south Social Worker) and Employee #17 (2 north Unit Manager). (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Complaint: [Employee #18] and [Employee #17] interviewed resident at bedside concerning a complaint he made about his care received. He stated that the aide handled him roughly during ADL (activities of daily living) care. He also stated that she appeared to be in a hurry. He stated ADL was being done while the respiratory therapist was providing trach care. He stated, 'It was too much on me.' - Investigation report: Social Worker and Nurse Manager interviewed resident at bedside and addressed his concerns about care received. Resident was reassured that all residents needs will be met in a timely manner, and he will be treated with dignity and respect. - Action Initiated: Staff in-service on providing gentle care during ADLs (activities of daily living). To also treat residents with dignity and respect. - Disposition: Staff education good. Unit Manager noted the issue and notified the resident. - Signed and dated by Employee #1 (Administrator) on 07/15/24. A face-to-face interview was conducted on 11/22/24 at 9:28 AM with Employee #18 and Employee #17. The following was stated: - Employee #17, We talked with him (Resident #56) at the bedside and provided him assurance about educating the staff about answering call lights, treating residents with respect and dignity, and handing the residents. I did not talk to the respiratory therapist, try to identify the aide who handled him roughly or get statements from them regarding what happened. Reports that get reported to the DOH are allegations of abuse, neglect, hitting a resident, verbal abuse, taking a resident's belongings. I wouldn't call a resident telling me that they were handled roughly abuse. - Employee #18 stated, I feel the same, I don't consider being 'roughly handled' to be abuse. During a face-to-face interview on 11/22/24 at 4:09 PM, Employee #1 (Administrator) stated, When an allegation of abuse is made and we can't pinpoint exactly when the alleged abuse occurred, we interview staff who worked the last 72 hours or more if needed to try to catch it. Being 'handled roughly by an aide' is not necessarily an allegation of abuse. What we do is look at circumstances, interview the resident with follow-up questions and do an initial inquiry to know which route to take as far as reporting to DOH and education to the staff. When asked did the facility identify or try to identify the aide or interview the respiratory therapist mentioned in the grievance, the employee stated, No. The findings showed that there was no documented evidence that the facility took the steps to investigate Resident #56's allegation of being handled roughly as evidenced by failure to try and identify or interview the aide or the respiratory therapist that was present when the alleged incident occurred, and the grievance filed. Cross Reference 22B DCMR Sec. 3233.5

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview for one (1) of 75 sampled residents, facility staff failed to provide adequate supervision and intervention to prevent one resident's aggressive behavior towards others from escalating as evidenced by a resident-to-resident altercation in the courtyard and subsequently, one resident sustaining an injury. (Residents #220 and #222) Findings include: Review of a facility-reported incidents showed the following altercations involving Resident #222 and #220. A. Resident #222 was admitted to the facility on [DATE] with the diagnosis of COPD [Chronic Obstructive Pulmonary Disease], HIV [Human Immunodeficiency Virus], Chronic Viral Hepatitis C, Asthma, Vitamin D Deficiency, Unspecified, Malignant Neoplasm of Endocervix, Low Back Pain, Muscle Weakness, Anemia, and Hypertension. Review of Resident #222's Quarterly Minimum Data Set (MDS) assessment dated [DATE] showed facility staff coded a BIMS [Brief Interview for Mental Status] summary score of 11, indicating moderate cognitive impairment, no potential indicators of psychosis, no physical or verbal symptoms, Supervision with set-up help only for ADL's [activity of daily living], and no limitations in range of motion. B. Resident #220 was admitted to the facility on [DATE] with a diagnosis of Paranoid schizophrenia, status epilepticus, acute hypoxic respiratory failure secondary to status epilepticus requiring intubation and sedation, acute delirium and essential hypertension. Review of Resident #220's Quarterly Minimum Data Set (MDS) assessment dated [DATE] showed he is self-ambulatory without the use of an assistive device. The residents have a BIMS summary Score of 06 indicating severe cognitive impairment. Section E (Behavior) Physical behavior's symptoms directed towards others (hitting, kicking, pushing, scratching, grabbing, abusing others sexually) and verbal behavioral symptoms directed towards others (threatening others, screaming at others, cursing at others coded as 1 indicating behaviors of this type occurred 1 to 3 days. Other behavior symptoms not directed toward others (physical syndrome such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing body wastes, or verbal/vocal symptoms like screaming disruptive sounds) coded as 2 indicating behavior of this type occurred 4 to 6 days but less than daily. Has the resident wandered coded 2 indicating behaviors of this type occurred 4 to 6 days but less than daily, Section G (Functional Status) Bed mobility, Transfer, locomotion on unit, locomotion off unit self-performance coded Supervision with one-person physical assist. Review Resident #220's Care Plan initiated on 7/27/2023 with Focus area: Resident is a smoker. Goal: Resident will not smoke without supervision. Intervention: Instruct the residents about the facility policy: location, times, and safety concerns. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nurses note dated 07/27/2023 14:15 documented, Resident #220 very upset. Exhibited verbal and physical behavior. Resident yelling at staff and other residents at will. Thrust fits with force and anger. Resident indicated that he wants to leave this place right now, kicking at the door, unapproachable, physically thrust soda bottle at CNA [certified Nursing Assistant] head and aiming to slap residents in the face. lifting chairs to throw and pushing tables in dining area. Resident takes off shoe and throw at resident and staff. Resident inconsolably. Subjective: Resident throws food/food trays on the floor/walls. Knocks residents 'drinks on the floor. Objective: He states verbatim. He wants everyone to die. He hates it here. He wants no food to eat. He wants to go home now. Contacted supervisor about behavior, contact the security for safety of staff and residents, Place residents in room area x [time] 1 CNA to monitor resident. Resident remains physically, verbally, and aggressive, Resident was seen by [Psych] on 7/22/23 (psychogeriatric services) for evaluation of mental status/adjust medication for behavioral disturbances. All medication was taken as directed. Review of the Physician Orders showed the following orders for Psychotropic medications for Resident #220: -7/21/23 Abilify (Aripiprazole) 10mg tablet Give 1 tablet by mouth at bedtime for Schizophrenia; -8/1/23 Ativan (Lorazepam) 0.5mg tablet Give 1 tablet by mouth two times a day for Anxiety ' -8/9/23 Ativan (Lorazepam) injection solution 2mg/ml, inject 2mg intramuscularly every 8hrs [hours] as needed for anxiety. Resident #220's August 2023 Medication Administration record revealed the following: -Ativan 0.5 mg by mouth was discontinued on 8/9/23. -Ativan 2mg injection to be started on 8/9/23, the spaces for 8/9, 8/10, 8/11, 8/12, and 8/13 allotted for Medication given were left blank indicating not given for 5 days. -Ativan injection 2mg [milligram] intramuscular was then given on 08/14/23 at 0107. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a facility reported incident (DC00012197) reported on 08/15/2023 at 09:50 AM to the state agency revealed, [Residnet #222] verbalized that another resident allegedly hit her on her left forearm while she was trying to get through the door at the courtyard. On head-to-toe assessment, the resident complained of pain to his [her] left forearm and rated pain 04/10 on a scale of 0-10. On further assessment, no swelling, bruising, discoloration, redness, or open areas noted on the left forearm or any other areas on the resident's body. [Dr. name] was notified and Ordered Stat X-ray of left upper extremity and PRN [as needed] Tylenol 325mg 2 tabs Q[every] 6 hours for pain. The resident is self RP [responsible party] and was notified of the attending physician orders and she verbalized understanding. Pain medication was administered and 30 minutes later the resident rated pain level 1/10. Resident son who is the first Emergency contact [son name] was called on [phone number] but was unable to be reached on the phone. The resident mother, who is her second Emergency Contact [mother name] was called on [phone number] and notified of the alleged incident. and the attending physician orders, and she verbalized understanding. During the conversation, resident Mother stated that When [the resident] my daughter, was 2 years old, she broke that same arm, and she was treated. Resident emergency contact was notified that she will be updated with the X-ray result, and she verbalized understanding. Mobile Medical Imaging was called, and a STAT X-ray was initiated. Resident remains in a stable condition at this time with no physical or respiratory distress noted. Resident is self-ambulatory, and she ambulates in and out of the unit. STAT X-RAY has been done awaiting result. Situational background assessment request (SBAR) dated 08/14/2023. The resident [resident #220] is self-ambulatory with a BIMS score of 6 and he is not a good historian. On assessment, the resident was confused requiring frequent redirection and was unable to verbalize if he allegedly hit another resident at the courtyard. The resident is calm with no agitation, anxiety or exhibiting any violent behaviors to self or others noted. The resident is currently on Ativan for anxiety and Abilify for Schizophrenia. All medications are tolerated with good effect. For safety reasons the attending physician ordered the resident to be immediately placed on 1:1 [one-to-one] until seen and cleared by a Psychiatrist. 1:1 monitoring initiated. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #222's medical record revealed a nursing note dated 8/15/2023 21:35 documenting, [Resident #222] X-ray result of Left Forearm was received on 8/15/2023 around 1:41 AM. The X-ray result of the left forearm showed a fracture of the distal radial and ulnar diaphysis. No dislocation is seen. The adjacent soft tissues appear unremarkable. The X-ray result also showed a normal examination of the elbow and the left humerus. The attending physician [Dr. name] was notified and ordered to transfer resident to the hospital for further evaluation and treatment. The resident was transferred to [hospital name]. The resident returned to the facility at about 2:20 pm on 8/15/2023. Per discharge paperwork from the hospital CT [Computerized Tomography] Spine Cervical without contrast shows no abnormalities and the ventricles and cortical sulci are within normal limits. CT Scan of the Cervical, thoracis, and lumbar spine showed no fracture, dislocation, or other acute bony abnormalities identified. The CT scan shows Right upper lobe infiltrate. X-Ray of left Humerus/shoulder complete shows no fracture of the humerus. The result also shows the resident has Osteopenia and Degenerative Joint Disease (DJD). X-Ray of Left upper forearm shows fracture of the distal ulna with posterior angulation at the fracture site. The fracture is not articular. X-ray of the wrist shows a transverse, nondisplaced fracture through the distal radial diaphysis. The visualized wrist and elbow are unremarkable. No significant soft tissue abnormality is identified. The resident was discharged with order for azithromycin 250 mg oral tablet 1 tab by mouth x 4 days for pneumonia. A cast/splint was applied to resident left forearm and resident will be scheduled for a follow-up orthopedics appointment in 2-3 weeks at [hospital name]. The attending physician was called and notified of resident returned to the facility, X-ray report/CT Scan findings and discharge summary report. The attending physician gave an order to add Osteopenia and Degenerative Joint Disease (DJD) to the diagnosis list. The attending physician also approved the order for azithromycin x 4 days for pneumonia. Residents remain in a stable condition, she is self-ambulatory without the use of an assistive device. Residents remain alert and oriented x 4 without any issues. Resident is self RP, but Emergency contact 1 who is residents son [son name] was called and notified of resident returned to the facility, hospital X-Ray/CT Scan results and follow-up orders and he verbalized understanding and appreciation. Resident follow-up Appointment has been scheduled at [hospital name] orthopedic department on 8/29/23 at 11:00 am Status post left Ulnar fracture & temporary splint. MD [medical doctor], resident, and resident emergency contact made aware. Resident remain in a stable condition with no physical or respiratory distress. Current plan of care (POC) will continue. It should be noted that Resident #220 was 5 days including the day of the altercation in the courtyard without his medication for anxiety. During a visit to the courtyard on 11/6/24 at 10:15 AM to evaluate the plastic smoke equipment Resident #220 used to hit Resident #222, Employee #7 [smoking monitor] was interviewed concerning resident supervision while in the courtyard. She stated the unit managers or security is called for residents that are aggressive to others while in the courtyard. She reported that staff was not able to reach both residents at the time to prevent Resident #220 from picking up the plastic smoke equipment and then proceeded to hit Resident #222 on her arm. She also stated, smoker aides are only supervising the residents for safe smoking. Review of the Smoking Aide Job description 11/5/24 at 11:00 AM showed, Supervise all smokers in all areas of the facility including non-designated area. Resident rights Report any complaints or grievances made by residents, report incidents or suspected incidents of resident abuse immediately. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The evidence showed that facility staff failed to provide adequate supervision and intervention to prevent Resident #220's aggressive behavior toward others from escalating into the resident altercation with Resident #222. It is to be noted Resident #220 was off his anxiety medication for 5 days [PRN anxiety medication not given] during the time he was out in the smoking area and engaged in a physical altercation with Resident #222, which resulted in Resident #222 fracturing her left forearm. During a face-to-face interview conducted on 11/14/2024 at approximately 3:00 PM with Employee#2 [clinical coordinator]. She acknowledged the findings and stated, The smoke aides are to monitor and supervise the residents that are outside in the courtyard. Cross Reference 22B DCMR Sec. 3269.1(L)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and staff interviews, for three (3) of 75 sampled residents, the facility staff failed to implement its own written policies and procedures for reporting allegations of abuse or neglect in the required timeframes for three residents. (Residents' #24, #216, and #412) The findings included: A review of the facility's policy titled Abuse, Neglect, Exploitation or Misappropriation -Reporting and investigations with a revision date of 01/24 documented the following: All reports of resident abuse, including injuries of unknown origin, neglect, exploitation, or theft/misappropriation of resident property, are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported. If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the Administrator and to other officials according to state law. The administrator or designee reports the suspicion to the following persons or agencies: The state licensing/certification agency responsible for surveying/licensing the facility; The local/state ombudsman; The resident's representative; Law enforcement officials; The resident's attending physician; and the facility medical director. Immediately is defined as: Within 2 hours of an allegation involving abuse or result in serious bodily injury; or Within 24 hours of an allegation that does not involve abuse or result in serious bodily injury 1) The facility staff failed to follow its policy to notify the State Agency of a resident-to-resident altercation in the required timeframe for Resident #24 and #216. 1A) Resident #24 was admitted to the facility on [DATE] with multiple diagnoses that included the following: Chronic Diastolic Congestive Heart Failure, Schizophrenia, Unspecified Dementia, Major Depressive Disorder and Tobacco Use. A review of a Facility Reported Incident (FRI) submitted to the State Agency on 10/26/23 at 10:13 AM, documented the following: Notified of resident-to-resident altercation. One of the resident transferred to the hospital for evaluation. Investigation initiated A review of Resident #24's medical record revealed the following: [Alert Note] dated 10/26/23 at 2:09 AM, A staff heard someone yelling for help and when staff went into the first floor dinning area observed this resident (Resident #24) hitting his roommate in the first floor dining room, with a chair. [Alert Note] dated 10/26/23 at 2:10 AM, Resident stated that he left his room to avoid excalation (sp) of argument between him and his roommate but his roommate followed him into the dining room and proceeded to engage him in coversation (sp) again. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095036	A. Building B. Wing	11/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Unique Rehabilitation and Health Center LLC	901 First Street NW Washington, DC 20001

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[Physicians Progress Note] dated 10/26/24 at 2:29 PM, Last night, (Resident #24) attacked another resident with a chair, which is a change from his baseline, as he has not attacked other residents previously. (Resident #24) continues to be resistant to care, and requires psychotropic medication, which he has refused. Interview attempt was unsuccessful as (Resident #24) became irritable, aggressive, and threatened harm to me. Based on this presentation, I believe that (Resident #24) requires a higher level of care than we can provide at this time, and would best benefit from treatment in inpatient psychiatric care for stabilization of his aggressive behavior, as well as work-up and treatment of chronic medicalconditions (sp). Discussion of the case was performed with another psychiatrist, (Doctors name) who is in agreement with this assessment and plan. Based on the above exam and presentation, I plan to file an FD-12 (admission record for emergency mental health observation and diagnosis) application for hospitalization for (Resident #24). 1B) Resident #216 was admitted to the facility on [DATE] with multiple diagnoses that included the following: Hemiplegia and Hemiparesis Following Other Cerebrovascular Disease Affecting Left Dominant side, Memory Deficit Following Other Cerebrovascular Disease, and Other seizures. Review of Resident #216's medical record revealed the following: [Alert Note] dated 10/26/23 at 1:16 AM Resident stated that his roommate had an argument with him in their room, however his room mate left the room and when he saw him in the dinning room he went to speak to him but roommate used some foul language on him and picked up a chair and hit him twice on his forehead and back of his head as well. [Alert Note] dated 10/26/23 at 1:17 AM, documented, Head to toe assessment done, resident observed with some bruising to his face, multiple areas of laceration to his right, left cheek,and neck, and contusions to scalp, back of the head, reports pain 2/10, he remained alert awake oriented, verbal with clear speech, MDnotified (sp), 911 called, police arrived, officer (Officer's Name) and her team arrived at the facility to take his statement/interview him and advised him to decide if he wants to press charges, case number 23-176 121 given, and he was taken to (hospital abbreviation name) for further examination and treatment per MD orders. [Nurse Progress Note] dated 10/26/23 at 7:39 AM, documented, Resident was engaged in a fight with his roommate (sp) last night at about 23:00AM (11:00 PM), per report. Assessment done,resident substained some skin bruises to his face. 911 and EMS (emergency medical services) called, resident was transfer to (Hospital abbreviation). A review of Resident #216's hospital Discharge summary dated [DATE] at 5:01 PM, documented the following: Discharge Diagnoses DKA (Diabetic Ketoacidosis), Facial Contusion, Assault. Presentation and Hospital Course presented to ED (emergency room) after reported involvement in a fight with his roommate in his nursing facility. Pt (patient) presented with right facial bruising/swelling, though pt (patient) is a poor historian and a full history was unable to be obtained from the patient Review of the facility's incident investigation revealed that the facility staff submitted the notification of this incident to the State Agency on 10/26/23 at 10:13 AM. There was resulting harm from the incident and there is no documented evidence that the facility staff notified the State Agency in the required two hour timeframe. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a face-to-face interview conducted on 11/19/24 at 12:44 PM, Employee #25 (1 South Unit Manager) stated that she was not certain why the incident was not reported to the State Agency in the required timeframe and that the supervisor who sent the report in late no longer works at the facility. 2) The facility staff failed to follow its policy to report an unusual incident involving Resident #412 who was found unresponsive and administered Naloxone (opioid antagonist) by staff, to the State Agency in the required time frames. Resident #412 was admitted to the facility on [DATE] with multiple diagnoses that included the following: Multiple Fractures Ribs Unspecified Side Subsequent Encounter for Fracture with Routine Healing, Traumatic Subcutaneous Emphysema, Other Pneumothorax, Alcohol Abuse, History of Falling, Cocaine Use, Cannabis Dependence, and Other Chronic Pain. A review of a Facility Reported Incident (FRI) was submitted by the facility to the State Agency on 03/11/21 at 5:04 PM, documented the following: On 3/9/2024 Resident was received alert and verbally responsive in his wheelchair. At about 6:00 pm the charge nurse was called by assign CNA (certified nurse aide) that resident is sitting in his wheelchair in his room with his head bent down. Charge nurse went there and saw resident in a deep sleep and looking drowsy unable to say what happen. Residents were put back to bed and made comfortable, head of bed elevated to improve breathing. V/S (vital signs) within normal range. The supervisor made aware came on the unit. MD (medical doctor) was made aware, Naloxone (opioid antagonist) 0.4 mg(milligrams)/ml (milliliters) intramuscular via left deltoid was given from the emergency kit and O2 2 L/m(liters per minute) via N/C (nasal canula) was also administered per MD order. A review of Resident #412's medical record revealed the following: Review of the MAR (Medication Administration record) showed that Resident #412 was administered Naloxone HCl (Opioid Antagonist) Injection Solution 0.4 MG/ML (milligrams/milliliter) (Naloxone HCl) (opioid antagonist) Inject 0.4 ml intramuscularly one time only for Drug overdose until on 03/09/24 at 7:35 PM. [Progress Note] dated 03/09/24 at 10:05 PM documented, Resident was received alert and verbally responsive in his wheelchair. About 6:00 pm writer was called by assign CNA (certified nurse aide) that resident is sitting in his wheelchair in his room with his head bent down. Writer went there, and saw resident in a deep sleep and looking drowsy unable to say what happen. Resident was put back to bed to be made comfortable. V/S (vital signs) within normal range. Supervisor made aware came on the unit. Naloxone (opioid antagonist) 0.4 mg/ml intramuscular via lift deltoid was given from the emergency kit. PRN SPO2(Oxygen saturation) 2L/hr (Liters per hour) via N/C (nasal canula) was also initiated. MD (medical doctor) was notified. Pharmacy called to replace emergency kit. Resident is self RP (representative). All due medications given as ordered. P O (by mouth) fluid encouraged. Skin is warm and dry to touch. Lying comfortable in his room with call light within his reach and bed in the lowest position. Denied pain at this time. Will continue to monitor. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[SBAR-(Situation Background Assessment Recommendations) -Physician/NP (Nurse Practitioner) PA (Physician Assistant) Communication Tool] dated 03/11/24, documented, Resident was received alert and verbally responsive in his wheelchair. About 6:00 pm charge nurse was called by assign (ed) (sp) CNA (certified nurse aide) that resident is sitting in his wheelchair in his room with his head bent down. charge nurse went there and saw resident in a deep sleep and looking drowsy unable to say what happen. Resident was put back to bed to be made comfortable. V/S (vital signs) within normal range. Supervisor made aware came on the unit. MD (medical doctor) made aware, naloxone 0.4mg(milligram)/ml (milliliter) intramuscular via left deltoid was given from the emergency kit and SPO2 (oxygen saturation) 2 L/M (liters per minute) via N/C (nasal canula) administered per MD's order. It is noted that the above SBAR Progress note documents the incident occurred on 03/09/24. The facility staff submitted the incident to the State Agency on 03/11/24 at 3:52 PM. During a face-to-face interview conducted on 11/25/24 at 3:40 PM, Employee #25 (1 South Unit Manager) stated that the incident happened on the weekend and when they (unit manager) came in on Monday they sent the report to the Department of Health (State Agency) on Monday. Employee #25 acknowledged the finding and stated that the facility's policy was not followed.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and staff interviews for four (4) of 75 sampled residents the facility staff failed to notify the State agency of allegations of abuse or neglect as evidenced by the following: a resident to resident altercation with injuries not being reported in the required 2-hour timeframe,a report of an unusual incident involving a resident who was found unresponsive and administered Naloxone by staff and an incident where a resident alleged he was handled roughly by a certified nurse aide. (Residents #24, #216, #412 and #56) The findings included: A review of the facility's policy titled Abuse, Neglect, Exploitation or Misappropriation -Reporting and investigations with a revision date of 01/24 documented the following: All reports of resident abuse, including injuries of unknown origin, neglect, exploitation, or theft/misappropriation of resident property, are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported. If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the Administrator and to other officials according to state law. The administrator or designee reports the suspicion to the following persons or agencies: The state licensing/certification agency responsible for surveying/licensing the facility; The local/state ombudsman; The resident's representative; Law enforcement officials; The resident's attending physician; and the facility medical director. Immediately is defined as: Within 2 hours of an allegation involving abuse or result in serious bodily injury; or Within 24 hours of an allegation that does not involve abuse or result in serious bodily injury 1) The facility staff failed to notify the State Agency of a resident-to-resident altercation in the required timeframe for Resident #24 and #216. 1A) Resident #24 was admitted to the facility on [DATE] with multiple diagnoses that included the following: Chronic Diastolic Congestive Heart Failure, Schizophrenia, Unspecified Dementia, Major Depressive Disorder and Tobacco Use. A review of a Facility Reported Incident (FRI) submitted to the State Agency on 10/26/23 at 10:13 AM, documented the following: Notified of resident-to-resident altercation. One of the resident transferred to the hospital for evaluation. Investigation initiated A review of Resident #24's medical record revealed the following: [Alert Note] dated 10/26/23 at 2:09 AM, A staff heard someone yelling for help and when staff went into the first floor dinning area observed this resident (Resident #24) hitting his roommate in the first floor dining room, with a chair. [Alert Note] dated 10/26/23 at 2:10 AM, Resident stated that he left his room to avoid excalation (sp) of argument between him and his roommate but his roommate followed him into the dining room and proceeded to engage him in coversation (sp) again. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[Physicians Progress Note] dated 10/26/24 at 2:29 PM Last night, (Resident #24) attacked another resident with a chair, which is a change from his baseline, as he has not attacked other residents previously. (Resident #24) continues to be resistant to care, and requires psychotropic medication, which he has refused. Interview attempt was unsuccessful as (Resident #24) became irritable, aggressive, and threatened harm to me. Based on this presentation, I believe that (Resident #24) requires a higher level of care than we can provide at this time, and would best benefit from treatment in inpatient psychiatric care for stabilization of his aggressive behavior, as well as work-up and treatment of chronic medicalconditions (sp). Discussion of the case was performed with another psychiatrist, (Doctors name) who is in agreement with this assessment and plan. Based on the above exam and presentation, I plan to file an FD-12 (admission record for emergency mental health observation and diagnosis) application for hospitalization for (Resident #24). 1B) Resident #216 was admitted to the facility on [DATE] with multiple diagnoses that included the following: Hemiplegia and Hemiparesis Following Other Cerebrovascular Disease Affecting Left Dominant side, Memory Deficit Following Other Cerebrovascular Disease, and Other seizures. Review of Resident #216's medical record revealed the following: [Alert Note] dated 10/26/23 at 1:16 AM Resident stated that his roommate had an argument with him in their room, however his room mate left the room and when he saw him in the dinning room he went to speak to him but roommate used some foul language on him and picked up a chair and hit him twice on his forehead and back of his head as well. [Alert Note] dated 10/26/23 at 1:17 AM, documented Head to toe assessment done, resident observed with some bruising to his face, multiple areas of laceration to his right, left cheek,and neck, and contusions to scalp, back of the head, reports pain 2/10, he remained alert awake oriented, verbal with clear speech, MDnotified (sp), 911 called, police arrived, officer (Officer's Name) and her team arrived at the facility to take his statement/interview him and advised him to decide if he wants to press charges, case number 23-176 121 given, and he was taken to (hospital abbreviation name) for further examination and treatment per MD orders. [Nurse Progress Note] dated 10/26/23 at 7:39 AM, documented Resident was engaged in a fight with his roommate (sp) last night at about 23:00AM (11:00 PM), per report. Assessment done,resident substained some skin bruises to his face. 911 and EMS (emergency medical services) called, resident was transfer to (Hospital abbreviation). A review of Resident #216's hospital Discharge summary dated [DATE] at 5:01 PM, documented the following: Discharge Diagnoses DKA (Diabetic Ketoacidosis), Facial Contusion, Assault. Presentation and Hospital Course presented to ED (emergency room) after reported involvement in a fight with his roommate in his nursing facility. Pt (patient) presented with right facial bruising/swelling, though pt (patient) is a poor historian and a full history was unable to be obtained from the patient Review of the facility's incident investigation revealed that the facility staff submitted the notification of this incident to the State Agency on 10/26/23 at 10:13 AM. There was a resulting harm from the incident that was first documented at 2:09 AM on 10/26/23, The facility therefore did not submit a notification of this incident within the required 2 hour timeframe. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a face-to-face interview conducted on 11/19/24 at 12:44 PM, Employee #25 (1 South Unit Manager) stated that she was not certain why the incident was not reported to the State Agency in the required timeframe and that the supervisor who sent the report no longer works at the facility. 2) The facility staff failed to report an unusual incident involving Resident #412 who was found unresponsive and administered Naloxone (opioid antagonist) by staff, to the State Agency in the required time frames. Resident #412 was admitted to the facility on [DATE] with multiple diagnoses that included the following: Multiple Fractures Ribs Unspecified Side Subsequent Encounter for Fracture with Routine Healing, Traumatic Subcutaneous Emphysema, Other Pneumothorax, Alcohol Abuse, History of Falling, Cocaine Use, Cannabis Dependence, and Other Chronic Pain. A review of a Facility Reported Incident (FRI) was submitted by the facility to the State Agency on 03/11/21 at 5:04 PM, documented the following: On 3/9/2024 Resident was received alert and verbally responsive in his wheelchair. At about 6:00 pm the charge nurse was called by assign CNA (certified nurse aide) that resident is sitting in his wheelchair in his room with his head bent down. Charge nurse went there and saw resident in a deep sleep and looking drowsy unable to say what happen. Residents were put back to bed and made comfortable, head of bed elevated to improve breathing. V/S (vital signs) within normal range. The supervisor made aware came on the unit. MD (medical doctor) was made aware, Naloxone (opioid antagonist) 0.4 mg(milligrams)/ml (milliliters) intramuscular via left deltoid was given from the emergency kit and O2 2 L/m(liters per minute) via N/C (nasal canula) was also administered per MD order. A review of Resident #412's medical record revealed the following: Review of the MAR (Medication Administration record) showed that Resident #412 was administered Naloxone HCl (Opioid Antagonist) Injection Solution 0.4 MG/ML (milligrams/milliliter) (Naloxone HCl) (opioid antagonist) Inject 0.4 ml intramuscularly one time only for Drug overdose until on 03/09/24 at 7:35 PM. [Progress Note] dated 03/09/24 at 10:05 PM documented Resident was received alert and verbally responsive in his wheelchair. About 6:00 pm writer was called by assign CNA (certified nurse aide) that resident is sitting in his wheelchair in his room with his head bent down. Writer went there, and saw resident in a deep sleep and looking drowsy unable to say what happen. Resident was put back to bed to be made comfortable. V/S (vital signs) within normal range. Supervisor made aware came on the unit. Naloxone (opioid antagonist) 0.4 mg/ml intramuscular via lift deltoid was given from the emergency kit. PRN SPO2(Oxygen saturation) 2L/hr (Liters per hour) via N/C (nasal canula) was also initiated. MD (medical doctor) was notified. Pharmacy called to replace emergency kit. Resident is self RP (representative). All due medications given as ordered. P O (by mouth) fluid encouraged. Skin is warm and dry to touch. Lying comfortable in his room with call light within his reach and bed in the lowest position. Denied pain at this time. Will continue to monitor. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[SBAR-(Situation Background Assessment Recommendations) -Physician/NP (Nurse Practitioner) PA (Physician Assistant) Communication Tool] dated 03/11/24, documented Resident was received alert and verbally responsive in his wheelchair. About 6:00 pm charge nurse was called by assign (ed) (sp) CNA (certified nurse aide) that resident is sitting in his wheelchair in his room with his head bent down. charge nurse went there and saw resident in a deep sleep and looking drowsy unable to say what happen. Resident was put back to bed to be made comfortable. V/S (vital signs) within normal range. Supervisor made aware came on the unit. MD (medical doctor) made aware, naloxone 0.4mg(milligram)/ml (milliliter) intramuscular via left deltoid was given from the emergency kit and SPO2 (oxygen saturation) 2 L/M (liters per minute) via N/C (nasal canula) administered per MD's order. It is noted that the above SBAR Progress note documents the incident occurred on 03/09/24. The facility staff submitted the incident to the State Agency on 03/11/24 at 3:52 PM. During a face-to-face interview conducted on 11/25/24 at 3:40 PM, Employee #25 (1 South Unit Manager) stated that the incident happened on the weekend and when they (unit manager) came in on Monday they sent the report in then. Employee #25 acknowledged the finding and stated that the facility policy was not followed. Cross Reference 22B DCMR 3232.4 3. Facility staff failed to report to the State Agency an incident where Resident #56 alleged that he was handled roughly by a Certified Nurse's Aide (CNA). Resident #56 was admitted to the facility on [DATE] with multiple diagnoses that included: Chronic Respiratory Failure, Malignant Neoplasm of Lower Gum and Mouth, and Dysphagia. Review of the resident's medical record revealed the following: A Modified admission Minimum Data Set (MDS) assessment dated [DATE] showed that facility staff coded: no speech; makes self-understood; able to understand others; a Brief Interview for Mental Status (BIMS) summary score of 14, indicating intact cognitive response; and no potential indicators of psychosis. A Resident - Family Complaint Form (facility's grievance form) document dated 07/15/24 documented: - [Resident #56] is the person initiating the report. - Date of incident: 07/15/24; date report completed 07/15/24. - Name of person receiving complaint: Employee #18 (Unit 2 north/south Social Worker) and Employee #17 (2 north Unit Manager). - Complaint: [Employee #18] and [Employee #17] interviewed resident at bedside concerning a complaint he made about his care received. He stated that the aide handled him roughly during ADL (activities of daily living) care. He also stated that she appeared to be in a hurry. He stated ADL was being done while the respiratory therapist was providing trach care. He stated, 'It was too much on me.' (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Investigation report: Social Worker and Nurse Manager interviewed resident at bedside and addressed his concerns about care received. Resident was reassured that all residents needs will be met in a timely manner, and he will be treated with dignity and respect. - Action Initiated: Staff in-service on providing gentle care during ADLs (activities of daily living). To also treat residents with dignity and respect. - Disposition: Staff education good. Unit Manager noted the issue and notified the resident. - Signed and dated by Employee #1 (Administrator) on 07/15/24. A face-to-face interview was conducted on 11/22/24 at 9:28 AM with Employee #18 and Employee #17. The following was stated: - Employee #17, We talked with him (Resident #56) at the bedside and provided him assurance about educating the staff about answering call lights, treating residents with respect and dignity, and handing the residents. I did not talk to the respiratory therapist, try to identify the aide who handled him roughly or get statements from them regarding what happened. Reports that get reported to the DOH are allegations of abuse, neglect, hitting a resident, verbal abuse, taking a resident's belongings. I wouldn't call a resident telling me that they were handled roughly abuse. - Employee #18 stated, I feel the same, I don't consider being 'roughly handled' to be abuse. During a face-to-face interview on 11/22/24 at 4:09 PM, Employee #1 (Administrator) stated, When an allegation of abuse is made and we can't pinpoint exactly when the alleged abuse occurred, we interview staff who worked the last 72 hours or more if needed to try to catch it. Being 'handled roughly by an aide' is not necessarily an allegation of abuse. What we do is look at circumstances, interview the resident with follow-up questions and do an initial inquiry to know which route to take as far as reporting to DOH and education to the staff. When asked did the facility identify or try to identify the aide or interview the respiratory therapist mentioned in the grievance, the employee stated, No. The findings showed that Resident #56 filed a grievance and reported to facility staff that an incident occurred where he alleged the aide handled him roughly during ADL care and that it was too much on me. However, facility staff did not consider the allegation abuse and therefore failed to report it to the State Agency or investigate. Cross Reference 22B DCMR Sec. 3232.4

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews and staff interviews for one (1) of 75 sampled residents, the facility staff failed to implement a comprehensive person-centered care plan for Resident #175 as evidenced by the staff failing to implement the residents falls care plan intervention to place the residents bed in the lowest position. (Resident #175) The findings included: Resident #175 was admitted to the facility on [DATE] with multiple diagnoses that included the following: Displaced Fracture of Base of Neck of Right Femur, Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting the Right Dominant Side, and Repeated Falls. Review of Resident #175's medical record revealed the following: [Care Plan] focus area initiated on 03/27/24 documented (Resident #175) is at risk for falls r/t (related to) muscle wasting and atrophy not elsewhere classified, multiple sites, muscle weakness, had the following interventions initiated on 03/27/24 anticipate and meet the residents needs, bed in lower position and follow facility fall protocol. A review of a Facility Reported Incident (FRI) DC#00013084 submitted to the State Agency on 08/28/24 at 8:53 AM, documented the following: On 8/26/24, the CNA (certified nurse aide) further stated that just about 5 minutes after he left resident's room, he heard a loud scream help, help. He rushed to the resident's room and observed the resident laying on his right side on the floor close to his bed. The MD (medical doctor) ordered the resident to be transferred to the hospital for further evaluation due to a laceration on the right eye Resident returned to the facility on 8/28/24. Upon review of the hospital paperwork and the medical director consulted and confirmed the meaning of the diagnostics studies with the radiologist, was noted that he had an acute over chronic subdural hematoma. Resident has a history of subdural hematoma due to falls prior to initial admission A review of a Facility Reported Incident (FRI) DC#00013161 submitted to the State Agency on 09/27/24 documented the following: Resident was on every hour rounding due to high risk of falling. Today at about 3pm, during routine round to resident room, resident was noted on the floor, fall documentation and neuro-check was initiated and upon pain assessment, resident complained of a right hip pain, (Medical Doctors name) was notified, and he gave an order for an X-ray of right-hip to be done. The x-ray was done on the resident and the result came in at 11pm noticeable of Mildly displaced acute right transcervical versus [NAME] (sp) cervical femoral neck fracture. The hips are congruent with mild joint space loss. Resident has been transferred to the nearest ER. During an observation conducted on 11/22/24 at 2:00 PM, Resident #175 was observed laying in a hospital style bed in his room with the head of the bed raised approximately 45 degrees and the entire bed was elevated at the highest height from the ground. A face-to-face interview was conducted at the time of observation with Employee #25 (1 South Unit Manager) who acknowledged the finding and who was observed by the surveyor lowering Resident #175's bed to the lowest position. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095036	A. Building B. Wing	11/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Unique Rehabilitation and Health Center LLC	901 First Street NW Washington, DC 20001

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a face-to-face interview conducted on 11/27/24 at 3:30 PM, Employee #35 (Director of Quality) stated that they are reeducating staff, and disciplinary actions have improved performance. Cross Reference 22B DCMR 3210.4 (a)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, for one (1) of 75 sampled residents, facility staff failed to follow the physician's order for narcotic pain administration. Resident #229. The findings included: Review of the facility's Physician Medication Orders policy dated 11/01/24 documented: - Medications shall be administered only upon the written order of a person licensed to prescribe such medications. Resident #229 was admitted to the facility on [DATE] with multiple diagnoses that included: Pain, Malignant Neoplasm of Left Female Breast, and Neoplasm Related Pain. Review of the resident's medical record revealed the following an admission Minimum Data Set (MDS) assessment dated [DATE] showing facility staff coded: clear speech; clear comprehension of others; able to make self-understood; received scheduled and as needed pain medication and received opioid medications in the last seven (7) days. A physician's order dated 11/25/24 directed, Hydromorphone (narcotic pain reliever) 2 milligrams (mg), give one (1) tablet by mouth every 4 hours as needed for chronic pain due to Malignant Neoplasm of Left Female Breast. During a narcotic count on 11/26/24 at 1:41 PM on unit 3 north with Employee #19 (Licensed Practical Nurse/LPN), Resident #229's Hydromorphone blister packet showed that it had 4 remaining tablets, and the Controlled Drug Administration Record sheet showed that the employee documented that Resident #229 was administered the Hydromorphone 2 mg, two (2) tablets on 11/26/24 at 11:15 AM. Review of Resident #229's physician's orders with Employee #19 revealed that the resident had no active order to administer Hydromorphone 2 mg, two tablets. When asked why she administered Hydromorphone 2 mg, two tablets instead of the ordered one tablet to Resident #229, Employee #19 did not provide an answer. The evidence showed that Employee #19 failed to follow the physician's order of administering 1 tablet of Hydromorphone 2 mg to Resident #229. It should be noted that Resident #229 did not suffer any harm or adverse effects from being administered the two tablets of Hydromorphone 2 mg. Cross Reference 22B DCMR Sec. 3225.1

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, for one (1) of 75 sampled residents, facility staff failed to provide ongoing in-service training related to abuse, neglect, and exploitation, per the facilities policy when there are allegations of abuse. (Resident #12) The findings included: A review of a facility policy titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating Policy documented, All reports of resident abuse, including injury of unknown origin, neglect, exploitation, or theft/misappropriation of resident property, are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported and Corrective Action: 5. The employee will obtain education for the incident prior to returning to work. Resident #12 was admitted to the facility on [DATE] with multiple diagnoses that included: Dementia, Aphasia and Seizure Disorder. A Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented: facility staff coded a Brief Interview for Mental Status (BIMS) summary score of '11,' indicating the resident was moderately impaired. Functional Abilities and Goals that documented: the resident required substantial/maximal assistance with dressing and showering; moderate/partial assist with toileting and used a cane and wheelchair for locomotion on/off the unit. A Facility Reported Incident (DC~12505) received by the State Agency on 01/03/24 at 18:03 (6:03 PM) documented, Resident get up about 3:20am and start shouting that someone just came to his room and hit him. I told him that maybe he was dreaming. Then after about 3 minutes one male CNA (Certified Nursing Assistant) come walking down the hallway and resident jump up and pull the wall decoration to hit the CNA and continue to accuse him of coming into his room and I had to call the security to intervein [intervene]. The CNA has to leave the floor to the classroom for safety reasons. Investigations are ongoing. A nursing progress note dated 01/05/24 at 17:52 (5:52 PM) documented, Final Summary Report and Investigation protocol initiated and The alleged male [CNA's name] was suspended from work pending investigation, he was educated on verbal and Physical abuse and that he will not work with Mr. Brake [NAME] going forward. A review of an undated document titled 'SNF (Skilled Nursing Facility) Clinic - [Employee's Name] - Tests Report' revealed no documented evidence that Employee #16 (CNA) received education on Abuse prior to returning to work after being suspended during an investigation into Resident #12's allegation of abuse. During a face-to-face interview conducted on 11/21/24 at 3:21 PM Employee #16 (CNA) stated, I wasn't even assigned to him, and I never went in his room and I was put out of work for about 2 or 3 days and came back and I don't recall receiving education. (continued on next page)

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a face-to-face interview conducted on 11/22/24 at 9:14 AM Employee #4 (Educator) acknowledged the findings and stated, When there is alleged abuse, the person doing the investigation will give education right away and The staff will get educated when they come back if they're suspended during the investigation. If unsubstantiated allegation, when staff is brought back anyone can give the education before the staff can go back to work. Cross Reference 22B DCMR § 3214.1