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	09/19/2025

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 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 observation, record reviews and staff interviews, for one (1) of three sampled residents, the facility staff failed to report an injury of unknown origin to the Administrator, and for two (2) of three sampled residents, the facility staff failed to report a resident-to-resident altercation to the Administrator of the facility and to other officials (including to the State Survey Agency, Adult Protective Services, and Metropolitan Police Department) within the required timelines per the facility's Abuse policy and federal regulations. Residents #1 and #2. The findings included: 1.Facility staff failed to report Resident #1's injury of unknown origin to the Administrator per the facility's policy as evidenced by:A review of the facility's policy entitled, Abuse, Neglect, Exploitation, revised on 01/01/25, documented: Injuries of unknown source - An injury should be classified as an injury of unknown source when all of the following criteria are met: The source of the injury was not observed by any person; and The source of the injury could not be explained by the resident; and The injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time.Reporting Allegations to the Administrator and Authorities, 1. If 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. Resident #1 was admitted to the facility on [DATE] with diagnoses that included: Dementia, Alzheimer's Dementia, Major Depressive Disorder, Cognitive Communication Deficit, Restlessness and Agitation, and Unspecified Psychosis.A review of Resident #1's medical record revealed: A quarterly minimum data set (MDS) assessment dated [DATE] that documented that Resident #1: had severely impaired cognitions,; displayed physical (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) and verbal behavioral symptoms towards others (e.g., threatening others, screaming at others, cursing at others) for 1 to 3 days; was independent with transferring in and out of bed ,and could ambulate independently at least 150 feet in the room or in the corridor.The following physician orders dated 04/17/25 at 3:00 PM that directed:- Anti-Psychotic: Targeted Behavior Monitoring: Kicking, yelling/screaming, hitting, hallucinations, delusions etc. If behavior is observed, document behavior with interventions and notify the provider every shift for behavior.- Clopidogrel Bisulfate Oral Tablet 75 mg (Clopidogrel Bisulfate (anticoagulant/blood thinner) Give 1 tablet by mouth one time a day related to Atherosclerotic Heart Disease of Native Coronary Artery without Angina Pectoris,- Monitor resident for bleeding, bruises and discoloration r/t (related to) anticoagulant every shift. Alert MD (Medical Director) for any changes and document in progress note every shift. A physician's order dated 08/28/25 at 7:00 AM that directed: Maintain resident on 1:1 every shift.A physician's order dated 08/28/25 at 5:00 PM that directed: Risperdal Oral Tablet 1 mg (Risperidone) Give 1 tablet by mouth two times a day for psychosis. A physician's order dated 08/28/25 at 5:00 PM that directed: Depakote Sprinkles Oral Capsule Delayed Release Sprinkle 125 MG (Divalproex Sodium) Give 2 capsule by mouth three times a day for mood swings. A review of an SBAR (Situation, Background, Assessment and (continued on next page)

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

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

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(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	Recommendation) - Physician/ Nurse Practitioner (NP)/Physician Assistant (PA) Communication Tool dated 09/05/25 that documented: Situation: Resident's daughter alleged that resident has been physically abused by the facility staff.Background: Dementia, Alzheimer's, Depression.Assessment: Resident is alert x 1 with confusion, changes in mental status. Not observed in pain or discomfort; Recommendation/Progress Note (PN): Resident daughter alleged that [Resident #1] has been physically abused by the facility staff, head-to-toe assessment done by the staff, skin is intact. MD notified investigation initiated. A review of an incident report [Incident 2621432] to the State agency on 09/05/25 that documented: Initial report: [Name of Resident #1] .was admitted to the facility on [DATE] with the Dx (diagnoses) Altered mental status, Dementia with psychotic disturbance of Alzheimer's disease, [and] Major depressive [disorder], to name a few of them. The resident[s] daughter alleged that [Name of Resident #1] has been physically abused by the facility staff. The resident is not in any distress at this time. The full investigation will follow.On 09/11/25, the facility submitted a final investigation report of the incident [Incident 2621432] to the State agency that documented: Final investigation report: The result of the investigation is as follows: The daughter reported that when she visited the resident, she had noticed a discoloration below his left eye and alleged trauma/abuse that may have been caused by facility staff. Immediately upon notification, a head-to-toe assessment was done on [Resident #1]. No new discoloration was noted anywhere near the left eye and no new indication of pain.uniform baseline pigmentation of the face and body; . The Medical Director was notified and ordered an x-ray of the face. X-ray done with a negative result of fracture.A review of the facility's investigation documents showed a written statement from Employee #4, Charge Nurse who was assigned to Resident #1 on 08/30/25 from 7:00 AM to 3:00 PM. The Employee's statement documented: Saturday morning made rounds on Unit 3 South. Resident [1] was facing the wall and daughter was in the room with resident. She didn't want him disturbed. [I] Went back into [the] room to administer AM medications [to the Resident]. The daughter had taken pictures and asked me, ?Who did this, if [the] resident was on one-to-one monitoring?' I asked the CNAs (Certified Nurse Assistants), ?Did anyone report any incident?' They all said ?No.'. The daughter said it looked like it happened last evening. I checked the computer system for any notes of the incident' there were none. The daughter asked for a washcloth to clean resident's face after breakfast, and an ice pack. [I] placed ice into a washcloth, as she asked. She kept asking, ?Who did this?' I couldn't indicate when it took place and who did it. During a telephone interview with Resident #1's representative on 09/19/25 at 9:32 AM, the representative stated that on 08/30/25 at around 7:00 AM while visiting Resident #1, she noticed discoloration under the Resident's left eye. She asked Employee #6, (1:1 Monitor/Certified Nurse Assistant/CNA assigned to Resident #1) if something happened to the Resident overnight that caused the discoloration under the Resident's left eye, and he said No. Resident #1's representative stated that she mentioned the discoloration to Employee #4 (Charge Nurse assigned to Resident #1 on 08/30/25), and she asked the Employee if she was aware of any incident which may have caused the Resident's injury. Employee #4 stated that she was not aware of any incident that occurred, and she stated that she would let the Unit Manager know about the Resident's injury. Resident #1's representative added that for several days she received no follow-up from the facility staff about the Resident's injury. On 09/05/25 she reported Resident#1's injury of unknown origin to Employee #5 (3 South Unit Manager) and alleged that the Resident had been abused by the facility staff. Further review of Resident #1's medical record showed no documented evidence that Employee #4 ever reported Resident #1's injury any other facility staff. The evidence showed that Employee #5 was first informed of Resident #1's injury of unknown origin by the Resident's representative on 09/05/25. Of note, Employees #4 and #5 were not available for interview during the survey. 2. Facility staff failed to report a resident-to-resident altercation between Resident #1 and Resident #2 to the Administrator and to other officials (including to the State Survey Agency, Adult Protective Services, and Metropolitan Police Department) within the required timelines per the facility's Abuse policy and federal regulations as evidenced by:A review of (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the facility's policy entitled, Abuse, Neglect, Exploitation, revised on 01/01/25, documented: 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.Verbal abuse includes the use of oral, written, or gestured communication, or sounds, to residents within hearing distance, regardless of age, ability to comprehend, or disability. Reporting Allegations to the Administrator and Authorities, 1. If 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. On 09/11/25, the facility submitted a final investigation report of the incident [Incident 2621432] to the State agency that documented: Final investigation report: The result of the investigation is as follows: The daughter reported that when she visited the resident, she had noticed a discoloration below his left eye and alleged trauma/abuse that may have been caused by facility staff .During the investigation, unit staff noted that the resident, [Resident #1], was walking up and down in the hallway and was accompanied by his assigned aide, and his foot unintentionally made contact with another resident's [Name of Resident #2] foot which made [Resident #2] upset. Per the aide, she reacted quickly to put herself between the two residents and called for help, to stop both residents from fighting. Other staff members intervened and helped to redirect the residents and take [Resident #1] to his room. Per the assigned aide's statement, she immediately got in between the residents; she did not see any physical altercation between them and did not witness any direct injury to the residents. Per the charge nurse's statement, the CNA (Certified Nurse's Assistant) who supervised [Resident #1] told her that when the two residents were about to fight, she intervened immediately and called for help and no physical altercation (contact) was reported. A. Resident #1 was admitted to the facility on [DATE] with diagnoses that included: Dementia, Alzheimer's Dementia, Major Depressive Disorder, Cognitive Communication Deficit, Restlessness and Agitation, and Unspecified Psychosis.A review of Resident #1's medical record revealed: A quarterly minimum data set (MDS) assessment dated [DATE] that documented that Resident #1: had severely impaired cognitions,; displayed physical (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) and verbal behavioral symptoms towards others (e.g., threatening others, screaming at others, cursing at others) for 1 to 3 days; was independent with transferring in and out of bed ,and could ambulate independently at least 150 feet in the room or in the corridor.A physician's order dated 08/28/25 at 7:00 AM that directed: Maintain resident on 1:1 every shift every shift.A physician's order dated 08/28/25 at 5:00 PM that directed: Risperdal Oral Tablet 1 mg (Risperidone) Give 1 tablet by mouth two times a day for psychosis. A physician's order dated 08/28/25 at 5:00 PM that directed: Depakote Sprinkles Oral Capsule Delayed Release Sprinkle 125 MG (Divalproex Sodium) Give 2 capsule by mouth three times a day for mood swings. A Psych Progress Note dated 09/11/2025 that documented: Chief Complaint/Reason for this Visit: Patient seen due to other behavioral disturbance.[Name of Resident #1], who has a history of dementia and major depressive disorder, underwent a thorough evaluation today after a recent incident.During this assessment, he demonstrated alertness and stability, with no signs of agitation or aggression. Collaborating closely with the nursing team, we confidently determined that it is safe for him to remain on the unit. The incident was thoroughly reviewed and deemed an accident, not a result of intentional behavior. B. Resident #2 was admitted to the facility on [DATE] with diagnoses that included: Metabolic Encephalopathy, Chronic Obstructive Pulmonary Disease (COPD), Mood [Affective] Disorder, Psychoactive Substance Abuse with Psychoactive-Induced Mood Disorder. Cognitive Communication Deficit, and Adjustment Disorder with Mixed Anxiety and Depressed Mood. A review of Resident #2's medical record revealed: An admission minimum data set (MDS) assessment dated [DATE] that documented that Resident #1 had a Brief Interview for Mental Status (BIMS) summary score of 03, that indicating that the Resident had severely impaired cognitions. In addition, staff documented that Resident #2: had displayed behavioral symptoms not directed toward others (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(e.g., physical symptoms such as hitting or scratching self, pacing, (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds) for 1 to 3 days; and required supervision or touching assistance when ambulating.A physician's order dated 08/21/25 that directed: Namenda Oral Tablet 10 MG (Memantine HCl) Give 1 tablet by mouth one time a day for Dementia related to Cognitive Communication Deficit.A revised care plan initiated on 03/11/25 that documented: Focus: [Resident #2's Name] has a mood problem r/t (related to) Disease Process. Goal: [Resident #2] is on Namenda oral tablet for dementia. [Resident #2] will have improved mood state (happier, calmer appearance, no s/sx (sign as and symptoms) of depression, anxiety or sadness. Interventions: .Monitor/record mood to determine if problems. A review of an SBAR (Situation, Background, Assessment and Recommendation) - Physician/ Nurse Practitioner (NP)/Physician Assistant (PA) Communication Tool dated 09/05/25 that documented: Situation: Per staff report another resident stepped on [Resident #2]'s foot and he reacted back by fighting with the resident;.Background: Metabolic Encephalopathy.Assessment: Head to toe assessment done and resident remain stable. No change in mental status.; Recommendation/Progress Note (PN): Per staff report another resident stepped on [Resident #2]'s foot and he reacted back by fighting with the resident. The staff present were able to separate both residents. Head to toe assessment done and resident remain[ed] stable. No new skin issue noted. MD and Psych NP made aware. Plan of care continued. A review of the facility's investigation packet for Incident #2621432 showed the following:1) Written Statement from Employee #6 (CNA/1:1 Monitor assigned to Resident #1 on 08/30/25), that documented: On that day I was working on 4th South when I was [asked] to float to 3 South for a one-to-one shift with [Name of Resident #1]. During the whole night the Resident (Resident #1) was sleeping. He woke up before 6:00 AM and decided to do a walking (sp.) [walk] so I have [had] to follow him. He went to his old room, but he didn't enter and then decided to walk back. He's [was] walking back to the exit door when he steps [stepped] on [Name of Resident #2]'s feet. Immediately he [Resident #2] tried to slap [Resident 3], but I was in the middle. Then I called my coworker for help. When they got there, they stopped him [Resident #2], and I took [Resident #1} back to his room. 2) A metropolitan police report dated 09/15/25 that documented CNN #25141427 Public Incident Reporting Party-1 (RP-1/Name of Facility's Director of Nursing]) . Public Narrative. On September 15th, 2025, officers responded to [Facility's Address] to complete a miscellaneous report. On scene, RP-1 [Reporting Party -1] reported that W-1 (Witness-1/Resident #1's daughter) shared images of SB-1(Subject-1/Resident #1) who had minor apparent injuries to the face. RP-1 reports that SB-1 sustained those injuries from an affray with a resident within [the] facility. No probable cause for arrest or allegation of elder abuse was found. During a telephone interview on 09/18/25 at 11:43 AM Employee #6 stated: I worked the night shift (11PM on 08/29/25 to 7:00 AM 08/30/25). I was the CNA and one-to-one (1:1) monitor assigned for Resident #1. I was walking with the Resident, at around 6:00 AM. As we turned back up the hall toward the nurses' station, I observed Resident #2 sitting in a chair near the nurses' station watching television. Resident #2 was not paying attention and did not move his feet. as me and Resident #1 were walking toward him. That is when I observed Resident #1 step on Resident #2's foot. Resident #2 then stood up and started hitting at Resident #1. I could not tell if the residents made physical contact or not, but I stepped between the two residents, and I called for help. My coworkers came to the nurses' station to assist me in separating the residents. We called the Charge Nurse who came out of the office. She followed us as we walked Resident #1 back to his room to see how he was doing, and she checked on Resident #2. Resident #1 put himself back in bed. The Resident was not observed with any bleeding or injury at that time. All of staff who worked on the floor of that shift knew what happened. I did not report the incident because I did not see the Residents make physical contact during their altercation, and since the charge nurse was aware of the incident between the residents, I thought the charge nurse would report it.During a telephone interview on 09/19/25 at 2:06 PM Employee #7 (3 South Charge Nurse not assigned to (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #1) stated that she was in the restroom, when she heard a CNA (Employee #6) call for assistance. By the time she got to the scene, she stated that she saw Employee #6 standing between Resident #1 and #2. She also reported that another CNA (Employee #8) had arrived to assist with separating the residents. She asked Employee #6 what happened. The Employee told her that Resident #1 stepped on Resident #2's foot by mistake, and Resident #2 started hitting at Resident #1. She then stepped between the residents and called for assistance. Employee #7 further stated, I did not see the actual incident between Residents #1 and #2. I just saw Employee #6 standing between the two residents. I did not see any injuries to either of the residents, or anything to report, so I did not report the incident. A review of Resident's #1 and #2 medical records, and a review of the facility's investigation documents showed no evidence that facility staff reported the altercation between Residents #1 and #2 that occurred on 08/30/25, to the Administrator, per the facility's abuse policy. As a result, the Administrator did not report the resident-to-resident altercation to the State Survey Agency, Adult Protective Services, and Metropolitan Police Department until 09/05/25, five days after the resident-to-resident altercation. On 09/18/25 a complaint survey to investigate Incident 2621432 was initiated by the State Agency. On 09/17/25, the facility had taken several actions to address the deficient practice of not reporting incidents of unknown origin and incidents of alleged abuse. Past Non-compliance InformationDuring a face-to-face interview conducted on 09/18/25 at 12:05 PM, Employee #1 (Administrator) indicated that the facility implemented interventions on or before September 17, 2025, to address the deficient practice. On 09/05/25 the following interventions were implemented:- The facility initiated an investigation of Resident 1's injury of unknown origin (discoloration under Resident's left eye) and the staff-to-resident physical abuse allegation reported by Resident #1's representative.- Resident #1 was assessed by the Unit Manager, the DON and the Administrator. - The Medical Director was made aware of the discoloration under Resident #1's left eye. An x-ay was ordered and completed in house. The x-ray results were negative. The Medical Director also came to the facility to assess the Resident.- The nursing staff who worked day and evening shifts on unit where Resident #1 resided, were asked to provide written statements regarding discoloration under Reisdent#1's left eye. Four staff provided account of an unreported altercation that occurred on 08/30/25 between Resident #1 and #2 in their written statements.- The 1:1 monitor /CNA, and the Charges Nurses were suspended pending the facility's investigation for Resident #1's injury of unknown origin and the investigation of the unreported altercation between Resident# 1 and #2. - The Psychiatrist was notified of Resident #1 altercation with Resident #2, and both Residents were assessed by the Psychiatrist. In addition, the Psychiatrist made - Mandatory education and training in-services were conducted on abuse and reporting incidents of unknown origin, starting with evening staff on 09/05/25. - Care plans for Residents #1 and #2 were updated.- A Performance Improvement Plan (PIP) for the facility was initiated. The PIP included a root cause analysis, away to track and improve On 09/08/25 the following interventions were implemented:- Implemented an audit tool for all residents in the facility for Allegations of Abuse, Identifying and Reporting Abuse and Injuries of Unknown Origin, and Reporting Changes. 100% audit was completed for Weeks 1 with no additional concerns identified. Weekly audits were to continue thereafter for 4 weeks x 2 months.- Psychiatrist provided additional n-service training on providing care for Residents with Dementia. On 09/11/25 the following interventions were implemented:- The investigation for Incident # was completed.- Employee#4 Charge Nurse for Resident #1 was terminated for failure to report an injury of unknown origin.- Employee #6 Assigned CNA for Resident on 08/30/25 was terminated, for failure to report a resident-to-resident altercation to the Charge Nurse. On 09/17/25, 90% of all facility staff had received the in-service training on Abuse, and on 09/18/25, 100% of all facility staff had received the in-service training on, Abuse, Identifying and Reporting Abuse and Injuries of Unknown Origin, and Reporting Changes.- Corrective actions were implemented and monitored, with ongoing oversight by the QAPI committee through November 30, 2025.