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	11/24/2025

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 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 resident and staff interviews, the facility staff failed to develop a care plan for one (1) of four (4) residents who used a powered(electric) wheelchair. (Resident #2).The findings included:Resident #2 was admitted to the facility on [DATE] with multiple diagnoses including Morbid Obesity, Chronic Bilateral Lower Extremities Lymphedema, and Muscle Weakness.An admission Minimum Data Set (MDS) assessment dated [DATE] documented in part that the resident had a Brief Interview Mental Status summary score of 15 indicating that at the time of the assessment the resident had an intact cognitive status. Also, the resident was coded for lower extremity impairment, requiring staff assistance when using a manual wheelchair, and receiving occupational therapy services. A delivery ticket from a local medical supply store dated 04/17/25 documented a power(electric) wheelchair was delivered to the facility for Resident #2.A quarterly Minimum Data Set (MDS) assessment dated [DATE] documented in part that the resident had a Brief Interview Mental Status summary score of 15 indicating that at the time of the assessment the resident had an intact cognitive status. Also, the resident was coded for lower extremity impairment, independently using a manual wheelchair, and receiving occupational therapy services. A review of a wheelchair and seating device assessment dated [DATE] documented, The resident on electric wheelchair demonstrates safe operation on the wheelchair.A review of the resident care plans showed there was no documented evidence of care plan to address the resident use of a manual or electric wheelchair.Multiple observation from 11/17/25 to 11/21/25 showed the resident in her room watching tv while sitting in a powered wheelchair. At the time of the observation on 11/17/25 at approximately 11AM, the resident stated that staff helps her transfer from the bed to her wheelchair. The resident also said that she can independently operate her (electric)wheelchair in her room, the bathroom, around the facility, and outside the facility.During a face-to-face interview on 11/24/25 at approximately 2PM, Employee #4 (RN/Unit Manager) reviewed the care plans. Then the employee stated that the resident's care plans did not have a care plan to address the resident's use of a powered (electric) wheelchair.

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

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	11/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, facility staff failed to have documented evidence that they followed their policy by providing education for one of four residents who used medical equipment (powered wheelchair). Resident #2The findings included:The facility's Resident Medical Equipment policy with a review date of 01/2025 instructed staff to, Document receipt of equipment. Documentation may include .date/time received, equipment type, delivered by (vendor, family member, etc.).Education on how to use the equipment may be provided for staff or for the resident.Resident #2 was admitted to the facility on [DATE] with multiple diagnoses including Morbid Obesity, Chronic Bilateral Lower Extremities Lymphedema, and Muscle Weakness.A delivery ticket from a local medical supply store dated 04/17/25 documented a power(electric) wheelchair was delivered to the facility for Resident #2.A review of resident's medical record to include progress notes from nursing, rehab and social services and inventory sheets dated from 04/17/25 to 06/05/25 lacked documented evidence that the resident received a powered wheelchair on 04/17/25.A review of a wheelchair and seating device assessment dated [DATE] documented, The resident on electric wheelchair demonstrates safe operation on the wheelchair.A review of progress notes from 06/05/25 to 07/03/25 revealed there was no documented evidence that staff provided the resident education on how to use a powered(electric) wheelchair. It should be noted that the resident was discharged home on [DATE] and re-admitted on [DATE].Multiple observations from 11/17/25 to 11/21/25 showed the resident in her room watching tv while sitting in a powered wheelchair. At the time of the observation on 11/17/25 at approximately 11AM, the resident stated that Employee #3 (Unit Manager/RN) and the technician who delivered the wheelchair provided education for her on the day the wheelchair was delivered. The resident, however, could not remember the specific date her electric wheelchair was delivered. Additionally, the resident stated the day her wheelchair was delivered was the first time she used an electric (powered) wheelchair. During a face-to-face interview on 11/19/25 at 2PM, Employee #3 stated that she provided education for the resident on how to safely operate her new powered wheelchair during her wheelchair assessment date 06/06/25. The employee then stated that it was an oversight that she did not document the education she provided in the resident's medical record. Additionally, the employee said that she could not remember the specific date the wheelchair was delivered and she did not see in the resident's record where nursing documented the date the resident's wheelchair was delivered.