STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	095024	A. Building B. Wing	11/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harborside Health & Rehabilitation	4601 Martin Luther King Jr Avenue SW Washington, DC 20032

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 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 reviews and staff interviews, for two (2) of seven (7) sampled residents, the facility staff failed to ensure residents' records contained accurate information. As evidence by:(1). Staff documented Resident #1 had a Gastrostomy Tube (G-tube) instead of a Jejunostomy Tube (J-Tube). (2) Staff documented Resident #4 had a right check bruise instead of a right eyebrow bruise. The findings included:1.Resident #1 was admitted on [DATE] with multiple diagnoses including Gastrostomy Status, Dysphagia, Encephalopathy, and Acute Respiratory with Hypoxia.A history and physical dated 07/25/25 documented in part, Gastrointestinal [system]-soft, non-distended, J-Tube.Assessment and Plan- Dysphagia Continue TF (tube feeding) per J-tube.A nursing progress note dated 07/29/25 at 5:28 PM documented in part, Abdomen is soft and non-tender with positive bowel sounds on all four quadrants . G- tube feeding is in progress. A nursing progress note dated 08/15/25 at 8:53 PM documented in part, On continuous G-tube feeding for nourishment. G-tube is intact, patent and infusing well. Abdomen is soft to slight touch, non-distended.A nursing note dated 09/05/25 at 7:50 AM documented in part, Resident is G-tube dependent, G-tube intact and patent. No foul smelling discharge noted at the G-tube site. Nepro infusing @ 40 ml(milliters)/ hr (hour)with hydration water flush 240 ml every 4 hrs. During a face-to-face interview on 09/19/25 at 10:35 AM, Employee #3 (RN/Unit Manger) stated that the staff documented g-tube in error. The resident had a J-tube and not a G-tube. 2.Resident #4 was admitted to the facility on [DATE] with multiple diagnoses including Dementia. A nursing note dated 08/26/25 at 11:09 AM documented in part, It was brought to this writer attention that, [resident's name] has skin discoloration on the right side on the top of her eye.On head-to-toe assessment, skin alteration noted on the top of the resident right eye. Appear yellow purplish measuring 1.1cm x 1.1cm, and on resident right upper lateral harm 3 spot of same color.A nursing note dated 08/26/25 at 5:18 PM documented in part, Small discoloration to right cheek remains the same no discomfort noted or s/s of pain.A care plan dated 08/27/25 documented in part, Focus- [Resident's name] has [a] skin discoloration.Intervention-monitor the resident discoloration site on her right forehead.During a face-to-face interview on 09/19/25 at 2:25 PM, Employee #4 (RN/Unit Manager) stated that the nurses note dated 08/26/25 at 5:18 PM was an error. The resident had a bruise above her right eyebrow not her right cheek.

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