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	03/03/2026

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

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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 review and staff interview, for one (1) of ten (10) sampled residents, facility staff failed to report, within two (2) hours, an incident that resulted in serious bodily injury, harm and or death. Resident #5.The findings included: The facility's Abuse Investigation and Reporting policy dated [DATE] documented in part:An alleged violation of abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately, but not later than two (2) hours if the alleged violation involves abuse OR has resulted in serious bodily injury. Resident #1 was admitted to the facility on [DATE] with multiple diagnoses that included: Acute Respiratory Failure with Hypoxia, Epilepsy, Dysphagia Following Cerebral Infarction, Diabetes Mellitus and Schizophrenia.Review of the resident's medical record showed the following: [DATE] at 3:00 AM Respiratory Therapy Note: Rapid Response was called to resident's room. Patient was found unresponsive on the floor by Nursing Supervisor. Cardiopulmonary resuscitation (CPR) was performed by Code Team.911 arrived continued with advanced Cardiovascular Life Support (ACLS) protocol.After several rounds of CPR, patient was pronounced deceased . [DATE] at 5:19 AM Nursing Note: During supervisor's round at 3 AM, resident was found on the floor by the door, lying in supine position unresponsive.CPR initiated and 911 was called. 911 arrived at 3:15 AM and took over and worked on him for about 30mins.The resident was pronounced dead at 3:51 AM. A Facility Reported Incident (FRI), intake #2785968, received by the State Agency on [DATE] at 7:26 PM documented, On February 22, 2026 at approximately 3 AM, [Resident #5] was found in the doorway of his room with his trach dislodged. An investigation is underway. The evidence showed that at facility staff reported the incident of Resident #5 being found lying on the floor, at the doorway of his room, unresponsive, with his trach dislodged, to the State Agency 16 and half hours after the incident had occurred. The evidence also showed that at the time that the incident was reported to the State Agency, facility staff failed to disclose that Resident #5's fall resulted in serious injury, harm and or death, even though they had knowledge of it. During a face-to-face interview on [DATE] at 2:02 PM, Employee #2 (Director of Nursing/DON) acknowledged the findings and made no comment. Cross Reference 22B DCMR Sec. 3232.4

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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident?s advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and staff interviews, for one (1) of 10 sampled residents, facility staff failed to accurately provide cardiopulmonary resuscitation (CPR) to Resident #5, who was found on the floor, without a pulse, not breathing, with a dislodged tracheostomy tube. During this survey, an Immediate Jeopardy (IJ-J) was identified at 42 CFR 483.24, Quality of Life, F678, Cardiopulmonary Resuscitation on February 25, 2026 at 3:40 PM. The facility's Administrator submitted an abatement plan to the Survey Team that was accepted on February 25, 2026 at 8:19 PM. The Survey Team verified implementation of the abatement plan while onsite and the immediate jeopardy was lifted on [DATE] at 10:45 AM. After removal of the immediacy, the deficient practice was lowered to a scope and severity level of D.The findings included: The facility's Emergency Procedure - Cardiopulmonary Resuscitation policy dated [DATE] documented in part:The facility's procedure for administering CPR shall incorporate the steps covered in the American Heart Association (AHA) Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care.If an individual is found unresponsive, briefly assess for abnormal or absence of breathing. If sudden cardiac arrest is likely, begin CPR.Instruct a staff member to activate the emergency response system (code) and call 911.Instruct a staff member to retrieve the automatic external defibrillator.Breathing: After 30 chest compressions provide 2 breaths via Ambu bag or manually (with CPR shield). According to the AHA: - Do not leave a person alone who has collapsed and requires CPR. You must stay with them, perform continuous chest compressions, and have someone else call 911 and fetch an Automated External Defibrillator (AED) if possible. Only stop CPR if the person wakes up, begins breathing normally, or professional help takes over. - The only exception to leaving is if it is necessary to call for help when you are completely alone and have no phone, but you should return immediately to start CPR.- CPR for a person with a tracheostomy involves 30 chest compressions at a rate of 100-120 per minute, followed by 2 breaths directly into the tracheostomy tube using a bag-valve mask (Ambu bag) or mouth-to-trach, ensuring the chest rises. If the tube is dislodged or blocked, replace it or cover the stoma to provide rescue breathing.Resident #1 was admitted to the facility on [DATE] with multiple diagnoses that included: Acute Respiratory Failure with Hypoxia, Epilepsy, Dysphagia Following Cerebral Infarction, Diabetes Mellitus and Schizophrenia.Review of the resident's medical record revealed the following: A physician's order dated [DATE] that directed, Full Code. Care plan focus area initiated on [DATE]: [Resident #5] is at risk for respiratory complications secondary to tracheostomy.Goal(s): The resident will be free from respiratory complications through the review period.Interventions: Administer medications as ordered; administer nebulizer treatments as ordered; administer oxygen as ordered; observe for signs and symptoms of respiratory complications through review period; vitals as needed. Care plan focus area initiated on [DATE]: [Resident #5] is at risk for cardiac complications secondary to hypertension.Goal(s): The resident will be free from cardiac complications through review period.Interventions: administer medications as ordered; cardiology referral as indicated per MD (medical doctor); diagnostics as ordered; labs as ordered; observe for signs and symptoms of cardiac complications; observe for signs and symptoms of fluid overload including pulmonary or lower extremity edema and shortness of breath and notify MD as indicated; pacemaker checks as scheduled; vital signs as needed. An admission Minimum Data Set (MDS) assessment dated [DATE] showed that facility staff coded: able to make self understood; a Brief Interview for Mental Status (BIMS) summary score of 13, indicating intact, cognitive response; had functional limitation in range of motion in both upper extremities, no impairment in lower extremities; used a walked mobility device; required partial/moderate assist of one staff for lying to sitting on side of bed; required supervision or touching assistance for sit to stand, chair/bed-to-chair transfer; and received oxygen, tracheostomy care and respiratory therapy services. [DATE] at 3:00 AM Respiratory (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Therapy Note: Rapid Response was called to resident's room. Patient was found unresponsive on the floor by Nursing Supervisor. Cardiopulmonary resuscitation (CPR) was performed by Code Team.911 arrived continued with advanced Cardiovascular Life Support (ACLS) protocol.After several rounds of CPR, patient was pronounced deceased . [DATE] at 5:19 AM Nursing Note: During supervisor's round at 3 AM, resident was found on the floor by the door, lying in supine position unresponsive.CPR initiated and 911 was called. 911 arrived at 3:15 AM and took over and worked on him for about 30mins.The resident was pronounced dead at 3:51 AM. A Facility Reported Incident (FRI), intake #2785968, received by the State Agency on [DATE] at 7:26 PM documented, On February 22, 2026 at approximately 3 AM, [Resident #5] was found in the doorway of his room with his trach dislodged. An investigation is underway. During a telephone interview on [DATE] at 10:29 AM, Employee #6 (Nurse Supervisor) stated, I saw the resident on the floor, close to the door, unresponsive. I did a little assessment, checked for a pulse and respirations. The oxygen tubing was still connected but the inner cannula (tracheostomy tube) had come out. I started CPR initially, but I noticed I had to call for help, So I left the resident alone and went to the nurse's station where I saw nursing staff sitting there and asked them for help and they came. I then called for a ?Rapid Response'. It was easy for me to get help because there were people sitting at the nurse's station. When asked why she didn't use the call light or scream for help, she stated, I was not close to the call light. The normal protocol is to call or shout for help. But it was 3 AM, and I didn't want to wake up the other residents. The nursing station wasn't far from where I was, so I ran to get help and came back. My issue was I didn't want to scream and wake other residents up. When asked what she did for CPR, the employee stated that she provided chest compressions for about the 3 minutes and did not provide ventilation via the tracheostomy site using an Ambu bag or any other form of rescue breathing. The employee was further asked, why she called ?Rapid Response' versus a ?Code Blue' when she knew that Resident #5 was unresponsive, pulseless, not breathing and she had provided CPR for 3 minutes with no response. Employee #6 stated, Everything was happening quickly. I called the ?Rapid Response' to get more people to come help and then the ?Code Blue was called. Once the code team was there, they said to call 911. Review of Employee #6's employee file showed that she was last certified/trained to administer CPR/Basic Life Support (BLS) using the AHA guidelines on [DATE]. During a telephone interview on [DATE] at approximately 11:00 AM, Employee #9 (Respiratory Therapist/RT) stated, My first encounter with [Resident #5] was between 10:30 PM - 11 PM. He was in the bed. I suctioned him, didn't get a lot. I did my treatment and left. He was stable. I heard the call for ?Rapid Response' while I was on 3 east and then a ?Code Blue' call. When I got to his room, I saw that the resident was on the floor, on his back. There were a few people just standing there, not administering CPR. I am not sure who they were. Once I got closer, I did an assessment and saw that he was not breathing so I grabbed Ambu bag from the bedside, hooked it up to oxygen and started doing compressions with one hand and giving [rescue] breaths with the other hand. By then another RT came, who helped me bag the resident. The resident's trach had dislodged; it was on the floor when I first entered the room. I was easily able to reinsert the trach with no incident. We continued CPR until a doctor came with the code team. Then EMS (emergency medical services) came and took over until the he (Resident #5 was pronounced dead. When asked what the difference between a Rapid Response and a Code Blue call is, Employee #9 stated, A rapid response could be anything, low sugar, a really high blood pressure. A code blue is when someone is pulseless and breathless. A rapid response is what was called first that night ([DATE], date on the incident.During a face-to-face interview on [DATE] that started at 11:23 AM, Employee #2 (Director of Nursing/DON) stated, All staff are trained on what qualifies as a ?Rapid Response' versus a ?Code Blue.' I got that as part of my training. Code blue is automatic when someone collapses and there's no pulse and or they are not breathing. The evidence showed that facility staff failed to accurately provide CPR to Resident #5, who was found on the floor, without a pulse, not breathing, with a dislodged tracheostomy tube. Resident #5 was subsequently pronounced deceased on [DATE] at 3:51 AM. Due to these failures, an (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Immediate Jeopardy (IJ-J) was identified on [DATE] at 3:40 PM. An abatement plan was submitted to the State Agency on [DATE] at 8:19 PM that was approved that entailed: Immediate Actions to Protect Residents: Resident #5, cannot be retroactively corrected for this resident.Immediate Corrective Actions Taken:CPR Response & ComplianceEffective immediately:Employee #6 has been removed from resident care pending investigation and re-education.All licensed nurses will be re-educated on:AHA CPR/BLS requirementsContinuous chest compressions without leaving the residentProper ventilation for residents with tracheostomies (use of Ambu bag via trach; management of dislodged trach)Clear differentiation between Code Blue and Rapid ResponseEducation will include:30 compressions at 100-120/minuteRescue breathing via tracheostomyProcedure if trach becomes dislodgedCPR Response and complianceMonitoring - CPR CompetencyAll licensed staff must maintain current AHA BLS certification.Quarterly mock Code Blue drills will be implemented.Monitoring - Emergency CallsCode Blue vs Rapid Response criteria posted at nurses' stations.Fall & Safety Assessment ComplianceImmediate Chart Audit100% audit of all residents with physician orders for fall/safety assessments will be reviewed for appropriateness and implementation:All physician orders for fall/safety assessments will be verified on MAR/TAR that they are being implementedAny missing documentation will be addressed immediately.Nurses will be re-educated on required documentation of ordered assessments.Care Plan Review100% audit of residents at risk for falls Care plans will be updated to include more than one individualized, multi-factor fall prevention interventions.EducationCare PlansCode Blue vs. Rapid Response CPR Response and CompliancePhysician orders/ImplementationFall/Safety AssessmentsEducation will be provided by the educator/designee for all licensed staff starting night shift on [DATE]. Education for all other licensed staff will occur prior to or at the start of their shift. Training will be ongoing until all licensed staff have been educated. Date of compliance: February 27, 2026. Cross Reference 22B DCMR Sec. 3214.2

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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 0684 Level of Harm - 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 interviews, for one (1) of ten (10) sampled residents, facility staff failed to administer 10 doses of Resident #71's ordered anticonvulsant medication from 06/06/25 through 06/12/25. Due to these failures, Resident #71 suffered harm as evidenced by having three (3) seizures during that time frame and required hospitalization. The findings included: Review of the facility policy titled, Medication and Treatment Orders dated 12/09/25 documented in part:Drugs and biologicals that are required to be refilled must be reordered from the issuing pharmacy not less than three (3) days prior to the last dosage being administered to ensure that refills are readily available. Resident #71 was admitted to the facility on [DATE] with multiple diagnoses that included: Convulsions, Hypertension and Spastic Hemiplegia Affecting Left Dominant Side. A physician's order dated 07/02/24 that directed, Lacosamide (antiseizure medication) oral tablet 200 MG (milligrams), give 1 tablet by mouth two times a day for Seizure precaution. A care plan reviewed on 04/22/25: [Resident #71] has Convulsion disorder related to head injury.Goal: Will be free from injury from seizure activity through the review date. Interventions: Give seizure medication as ordered by doctor. Monitor/document side effects and effectiveness. A Quarterly Minimum Data Set (MDS) assessment dated [DATE] showed that facility staff coded: a Brief Interview for Mental Status (BIMS) summary score of 15, indicating intact cognitive status; no rejection of care behaviors; had an active diagnosis of Epilepsy, unspecified, intractable, with status Epilepticus; and received anticonvulsant medications. A Controlled Substance Prescription document dated 06/06/25 showed that a Physician's Assistant (PA), wrote the prescription for Resident #71's Lacosamide 200 mg tablets. Review of the Resident #71's Lacosamide tablet 200 MG Controlled Drug Receipt/Record/Disposition Form dated 05/22/25 showed that the last available dose was administered on 06/06/25 at 10 PM by Employee #7 (Licensed Practical Nurse/LPN). The count documented 0 tablets remaining. 06/09/25 at 5:19 PM Nursing Progress Note: Security brought resident on the unit and stated that when he called resident name he did not respond like he used to. Writer and unit manager assess resident. Medical doctor made aware, assessed the resident, no new order given. 06/11/25 at 9:56 AM Health Status Note: Writer responded to a page to the first floor at 8 AM, security staff reported the resident took 2 puffs of smoke and started seizing. Resident was observed bleeding in his mouth coming from his tongue which he bit during the seizure.911 was called and the resident was transported to [Hospital Name]. 06/11/25 at 11:37 PM Nursing Progress Note: Resident returned from [Hospital Name] emergency room (ER) at 9:20 PM in stable condition. 06/12/25 at 7:36 AM: A fax report showed that the prescription written on 06/06/26 was faxed to the pharmacy for delivery. 06/12/25 at 8:24 AM Nursing Progress Note:MD notified that resident did not have Lacosamide 200 MG tablet. 06/12/25 at 8:52 AM Psychosocial Note: Asked to see the patient as per the nursing due to a change in mental status, upon arrival in the room, the patient was having a clinic tonic seizure, and a rapid response was called. 06/12/25 at 9:37 AM Health Status Note: Writer was notified in the morning by outgoing nursing staff (Employee #7/LPN) that the resident had a seizure and one episode of coffee brown emesis.MD had ordered STAT labs to be drawn; while putting in the orders resident had another seizure, rapid response was called.MD ordered to transfer the resident out to the hospital for evaluation.Resident was transported to [Hospital Name] ER by 911. Review of the Omnicell (automated medication and supply system) inventory for June 2025 showed that there were six (6) Lacosamide 200 mg tablets in stock and available in the facility. Review of the June 2025 Medication Administration Record (MAR) showed that facility staff documented 5 (5=Hold/See Progress Notes) and their initials at 10 AM on 06/07/25, 06/08/25 and 06/09/25; facility staff documented a 9 (9=Other/See Progress Notes) and their initials on 06/08/25 at 10 PM, 06/10/25 at 10 AM and 10 PM, and on 06/11/25 at 10 AM, meaning that Lacosamide oral tablet 200 MG was not administered to Resident #71. Further review of the June 2025 MAR showed that Employee #7 documented a check (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	mark and her initials to indicate that she administered Lacosamide 200 MG tablet to Resident #71 on 06/07/25 at 10 PM, 06/09/25 at 10 PM, and on 06/11/25 at 10 PM. However, there is no documented evidence that the Lacosamide tablets were taken out of the Omnicell or that the medication had been delivered from the pharmacy. A Facility Reported Incident (FRI), intake #231646, submitted online to the State Agency on 06/13/25 at 5:33 PM documented, On 6/12/2025 I was informed that a nurse taking care of [Resident #71] had signed off that she had administered his Lacosamide tab 200 mg anticonvulsant 6/7, 6/9, 6/11/2025 however when I reviewed the controlled drug disposition form the last dose was administered on 6/6/25. The nurse signed that the medication was administered but upon investigation the patient had not received the medication. A follow-up to FRI #231646 received by the State Agency on 06/20/25 at 3:17 PM documented in part: On June 12, 2025, the facility was informed of a medication administration discrepancy involving [Resident #71].[Employee #7/LPN) documented the administration of Lacosamide 200 mg on June 7, June 9, and June 11, 2025. However, upon review of the medication administration records and pharmacy records, it was determined that the last verified dose was administered on June 6, 2025. The pharmacy further confirmed that no additional doses had been ordered or delivered after that date. This indicates that the resident did not receive his prescribed seizure medication as scheduled. As a result, the resident was transferred to the hospital for evaluation and treatment. 06/20/25 Hospital Discharge Summary: Reason for visit - seizures. 06/20/25 at 10:32 PM Nursing Progress Note: Resident was admitted to the facility at 7:25 PM from [Hospital Name] after being treated for seizure and bacteremia. The evidence showed that Resident #71 missed a total of 10 doses of his ordered Lacosamide 200 MG tablets. The evidence also showed that facility staff failed to (1): fax Resident #71's Lacosamide 200 MG prescription to the pharmacy on 06/06/25; (2) administer the resident's Lacosamide 200 MG tablet even though there were 6 doses available in the facility's Omnicell; and (3) make the resident's physician aware that he missed multiple doses of his medication. During a face-to-face interview on 02/26/26 at 12:56 PM, Employee #1 (Administrator) and #2 (Director of Nursing/DON), they acknowledged the findings with Employee #1 stating, The nurse (Employee #7) was fired because of the incident. All licensed nurses were provided with education on accurate documentation practices, controlled substances handling procedures and consequences of falsification of documents. The doctor should've been made aware as soon as the resident had missed a medication dose, regardless of the reason. All licensed nurses have access to the Omnicell. Cross Reference 22B DCMR Sec. 3211.1

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and staff interviews, for one (1) of ten (10) sampled residents, facility staff failed to have an extra tracheostomy tube at Resident #6's bedside in the event of an accidental dislodgment or decannulation.The findings included: A facility policy titled, Unplanned Decannulation: Risk Assessment, Precautions and Interventions dated 12/09/25 documented in part: A replacement airway must be kept at the bedside for all airway patients. Resident #6 was admitted to the facility on [DATE] with multiple diagnoses that included: Acute and Chronic Respiratory Failure with Hypoxia, Chronic Kidney Disease and Hyperkalemia. Review of the resident's medical record showed the following: A Quarterly Minimum Data Set (MDS) assessment dated [DATE] that showed facility staff coded: a Brief Interview for Mental Status (BIMS) summary score of 14, indicating intact cognitive response; received oxygen therapy, suctioning, and tracheostomy (trach) care. Care plan focus area initiated on 01/08/26: The resident is at risk for respiratory complications secondary to Chronic Obstructive Pulmonary Disease (COPD), Respiratory Failure.Goal: the resident will be free from respiratory complications through the review period.Interventions: administer oxygen as ordered; head of bed elevated to prevent shortness of breath as tolerated; observe for signs and symptoms of respiratory complications through review period. A physician's order dated 02/24/26 that directed, FiO2 (Fraction of Inspired Oxygen): 28%;Trach Type - Shiley; Trach Size- 6.5 cuffless, every shift for Respiratory Failure, wean FIO2 as tolerated and to keep sats greater than 92%. During an observation on 02/24/26 at 10:34 AM, Resident #6 was observed in her room, sitting in a black wheelchair. The resident had a tracheostomy with a speaking valve on. Upon inspection, it was noted that there was not a spare trach tube anywhere in the resident's room.At 10:36 AM, Employee #3 (Licensed Practical Nurse/LPN), Resident #6's assigned nurse was called to the resident's room and asked where the resident's spare tracheostomy tube is located. The employee looked behind the bed, on the bed, in the bedside drawers, and did not find a spare tracheostomy. I didn't know she didn't have one. Maybe there's one for her in the respiratory cart.During a face-to-face interview on 02/24/26 at 11:48 AM, Employee #4 (Director of Respiratory Therapy) stated, Respiratory therapy is responsible for setting up and placing spare tracheostomy (trach) and any other emergency equipment at the resident's bedside like an Ambu bag (a handheld, manual resuscitator used to provide positive pressure ventilation to individuals with inadequate or stopped breathing). All airway patients, except laryngectomy patients, must have a spare trach at their bedside in case of accidental dislodgement. The surveyor informed Employee #4 that Resident #6 did not have one. Employee #4 then got on the phone with Employee #5 (Respiratory Therapist/RT) who was the assigned RT for the unit Resident #6 was on. Employee #4 instructed Employee #5 to go to Resident #6's room, look and make sure that there was a spare trach at her bedside. Employee #4 placed Employee #5 on speaker as he went to Resident #6's room. Upon searching, Employee #5 stated over the phone, There's no spare trach for Resident #6. When asked why the resident did not have a spare trach at her bedside, Employee #5 stated, I don't know, I just got here.The evidence showed that facility staff failed to have emergency equipment available for accidental dislodgment for a Resident #6 who has a tracheostomy. Cross Reference 22B Sec. 3215.6

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and staff interviews, for two (2) of ten (10) sampled residents, facility staff failed to demonstrate the competencies and skills sets to provide safe nursing and related services. Residents' #5 and #71.The findings included:1.Facility staff failed to call for help, immediately activate a Code Blue and accurately provide cardiopulmonary resuscitation (CPR) to Resident #5, who was found on the floor, without a pulse, not breathing, with a dislodged tracheostomy tube. The facility's Emergency Procedure - Cardiopulmonary Resuscitation policy dated [DATE] documented in part:The facility's procedure for administering CPR shall incorporate the steps covered in the American Heart Association (AHA) Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care.If an individual is found unresponsive, briefly assess for abnormal or absence of breathing. If sudden cardiac arrest is likely, begin CPR.Instruct a staff member to activate the emergency response system (code blue) and call 911.Instruct a staff member to retrieve the automatic external defibrillator.Breathing: After 30 chest compressions provide 2 breaths via Ambu bag or manually (with CPR shield). Resident #5 was admitted to the facility on [DATE] with multiple diagnoses that included: Acute Respiratory Failure with Hypoxia, Epilepsy, Dysphagia Following Cerebral Infarction, Diabetes Mellitus and Schizophrenia. Review of the resident's medical record revealed the following: A physician's order dated [DATE] that directed, Full Code. An admission Minimum Data Set (MDS) assessment dated [DATE] showed that facility staff coded: able to make self understood; a Brief Interview for Mental Status (BIMS) summary score of 13, indicating intact, cognitive response; received oxygen, tracheostomy care and respiratory therapy services. [DATE] at 5:19 AM Nursing Note: During supervisor's round at 3 AM, resident was found on the floor by the door, lying in supine position unresponsive.CPR initiated and 911 was called. 911 arrived at 3:15 AM and took over and worked on him for about 30mins.The resident was pronounced dead at 3:51 AM. A Facility Reported Incident (FRI), intake #2785968, received by the State Agency on [DATE] at 7:26 PM documented, On February 22, 2026 at approximately 3 AM, [Resident #5] was found in the doorway of his room with his trach dislodged. An investigation is underway. During a telephone interview on [DATE] at 10:29 AM, Employee #6 (Nurse Supervisor) stated, I saw the resident on the floor, close to the door, unresponsive. I did a little assessment, checked for a pulse and respirations. The oxygen tubing was still connected but the inner cannula (tracheostomy tube) had come out. I started CPR initially, but I noticed I had to call for help, So I left the resident alone and went to the nurse's station where I saw nursing staff sitting there and asked them for help and they came. I then called for a ?Rapid Response'. It was easy for me to get help because there were people sitting at the nurse's station. When asked why she didn't use the call light or scream for help, she stated, I was not close to the call light. The normal protocol is to call or shout for help. But it was 3 AM, and I didn't want to wake up the other residents. The nursing station wasn't far from where I was, so I ran to get help and came back. My issue was I didn't want to scream and wake other residents up. When asked what she did for CPR, the employee stated that she provided chest compressions for about the 3 minutes and did not provide ventilation via the tracheostomy site using an Ambu bag or any other form of rescue breathing. The employee was further asked, why she called ?Rapid Response' versus a ?Code Blue' when she knew that Resident #5 was unresponsive, pulseless, not breathing and she had provided CPR for 3 minutes with no response. Employee #6 stated, Everything was happening quickly. I called the ?Rapid Response' to get more people to come help and then the ?Code Blue was called. Once the code team was there, they said to call 911. Review of Employee #6's employee file showed that she was last certified/trained to administer CPR/Basic Life Support (BLS) using the AHA guidelines on [DATE]. The evidence showed that facility staff failed to call for help, immediately activate a Code Blue and accurately provide CPR to Resident #5, who was found on the floor, without (continued on next page)

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	095024	A. Building B. Wing	03/03/2026

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

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a pulse, not breathing, with a dislodged tracheostomy tube. Resident #5 was subsequently pronounced deceased on [DATE] at 3:51 AM. During a face-to-face interview on [DATE] that started at 11:23 AM, Employee #2 (Director of Nursing/DON) stated, All staff are trained on what qualifies as a ?Rapid Response' versus a ?Code Blue.' I got that as part of my training. Code blue is automatic when someone collapses and there's no pulse and or they are not breathing. 2. Facility staff failed to ensure that Resident #71 received his Lacosamide (anticonvulsant medication) 200 MG (milligrams) as ordered by the physician. Review of the facility policy titled, Medication and Treatment Orders dated [DATE] documented in part:Drugs and biologicals that are required to be refilled must be reordered from the issuing pharmacy not less than three (3) days prior to the last dosage being administered to ensure that refills are readily available. Resident #71 was admitted to the facility on [DATE] with multiple diagnoses that included: Convulsions, Hypertension and Spastic Hemiplegia Affecting Left Dominant Side. A physician's order dated [DATE] that directed, Lacosamide oral tablet 200 MG, give 1 tablet by mouth two times a day for Seizure precaution. A care plan reviewed on [DATE]: [Resident #71] has Convulsion disorder related to head injury.Goal: Will be free from injury from seizure activity through the review date. Interventions: Give seizure medication as ordered by doctor. Monitor/document side effects and effectiveness. A Quarterly Minimum Data Set (MDS) assessment dated [DATE] showed that facility staff coded: a BIMS summary score of 15, indicating intact cognitive status; no rejection of care behaviors; had an active diagnosis of Epilepsy, unspecified, intractable, with status Epilepticus; and received anticonvulsant medications. A Controlled Substance Prescription document dated [DATE] showed that a Physician's Assistant (PA), wrote the prescription for Resident #71's Lacosamide 200 mg tablets. Review of the Resident #71's Lacosamide tablet 200 MG Controlled Drug Receipt/Record/Disposition Form dated [DATE] showed that the last available dose was administered on [DATE] at 10 PM by Employee #7 (Licensed Practical Nurse/LPN). The count documented 0 tablets remaining. [DATE] at 9:56 AM Health Status Note: Writer responded to a page to the first floor at 8 AM, security staff reported the resident took 2 puffs of smoke and started seizing. Resident was observed bleeding in his mouth coming from his tongue which he bit during the seizure.911 was called and the resident was transported to [Hospital Name]. [DATE] at 11:37 PM Nursing Progress Note: Resident returned from [Hospital Name] emergency room (ER) at 9:20 PM in stable condition. [DATE] at 7:36 AM: A fax report showed that the prescription written on [DATE] was faxed to the pharmacy for delivery. [DATE] at 8:24 AM Nursing Progress Note:MD notified that resident did not have Lacosamide 200 MG tablet. [DATE] at 8:52 AM Psychosocial Note: Asked to see the patient as per the nursing due to a change in mental status, upon arrival in the room, the patient was having a clinic tonic seizure, and a rapid response was called. [DATE] at 9:37 AM Health Status Note: Writer was notified in the morning by outgoing nursing staff (Employee #7/LPN) that the resident had a seizure and one episode of coffee brown emesis.MD had ordered STAT labs to be drawn; while putting in the orders resident had another seizure, rapid response was called.MD ordered to transfer the resident out to the hospital for evaluation.Resident was transported to [Hospital Name] ER by 911. Review of the Omnicell (automated medication and supply system) inventory for [DATE] showed that there were six (6) Lacosamide 200 mg tablets in stock and available in the facility. Review of the [DATE] Medication Administration Record (MAR) showed that facility staff documented 5 (5=Hold/See Progress Notes) and their initials at 10 AM on [DATE], [DATE] and [DATE]; facility staff documented a 9 (9=Other/See Progress Notes) and their initials on [DATE] at 10 PM, [DATE] at 10 AM and 10 PM, and on [DATE] at 10 AM, meaning that Lacosamide oral tablet 200 MG was not administered to Resident #71. Further review of the [DATE] MAR showed that Employee #7 documented a check mark and her initials to indicate that she administered Lacosamide 200 MG tablet to Resident #71 on [DATE] at 10 PM, [DATE] at 10 PM, and on [DATE] at 10 PM. However, there is no documented evidence that the Lacosamide tablets were taken out of the Omnicell or that the medication had been delivered from the pharmacy. A Facility Reported Incident (FRI), intake #231646, submitted online to (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the State Agency on [DATE] at 5:33 PM documented, On [DATE] I was informed that a nurse taking care of [Resident #71] had signed off that she had administered his Lacosamide tab 200 mg anticonvulsant 6/7, 6/9, [DATE] however when I reviewed the controlled drug disposition form the last dose was administered on [DATE]. The nurse signed that the medication was administered but upon investigation the patient had not received the medication. The evidence showed that facility staff failed to fax Resident #71's Lacosamide 200 MG prescription to the pharmacy on [DATE]; failed to administer the resident's Lacosamide 200 MG tablet even though there were 6 doses available in the facility's Omnicell; and failed to make the resident's physician aware that he missed multiple doses of his medication. During a face-to-face interview on [DATE] at 12:56 PM, Employee #1 (Administrator) and #2 (Director of Nursing/DON), they acknowledged the findings with Employee #1 stating, The nurse (Employee #7) was fired because of the incident. All licensed nurses were provided with education on accurate documentation practices, controlled substances handling procedures and consequences of falsification of documents. The doctor should've been made aware as soon as the resident had missed a medication dose, regardless of the reason. All licensed nurses have access to the Omnicell. Cross Reference 22B DCMR Sec. 3210.4

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews and staff interviews, for three (3) of ten (10) sampled residents, facility staff failed to ensure controlled substances were reconciled as evidenced by not signing off the controlled medication forms when medications were administered. Residents' #9, #11, and #10. The findings included: Resident #9 was admitted to the facility on [DATE] with multiple diagnoses that included: Neuralgia and Neuritis, Hypertension, and Encephalopathy. Review of the resident's medical record revealed the following: A physician's order dated 10/06/25 that directed, Tramadol (narcotic pain reliever) HCl (hydrochloride) oral tablet 50 MG (milligrams), give 1 tablet by mouth every 6 hours as needed (PRN) for right arm pain. A Quarterly Minimum Data Set (MDS) assessment dated [DATE] that showed facility staff coded: a Brief Interview for Mental Status (BIMS) summary score of 05, indicating severely impaired cognitive response; received PRN pain medications; and was taking opioid mediations. During a controlled substances reconciliation on unit 2 east on 02/26/26 at 12:00 PM with Employee #3 (Licensed Practical Nurse/LPN), it was noted that Resident #9's controlled substance form for Tramadol 50 MG documented 2 tablets remaining. However, the blister packet had only 1 tablet remaining. Employee #3 stated, I just gave the medication to her (Resident #9), and I forgot to sign it off. I know I'm supposed to sign off the medication when I pop it to give. 2. Resident #11 was admitted to the facility on [DATE] with multiple diagnoses that included Pain, Neuralgia, Neuritis, and Muscle Spasms. Review of the resident's medical record revealed the following: A physician's order dated 09/11/24 that directed, Pregabalin (narcotic medication for nerve pain) oral capsule 150 MG, give 1 capsule by mouth two times a day for neuropathy pain. A Quarterly MDS assessment dated [DATE] showed that facility staff coded: a BIMS summary score of 15 indicating intact cognitive response and received opioid medications. During a controlled substances reconciliation on unit 2 east on 02/26/26 at 12:02 PM with Employee #3 (LPN), it was noted that Resident #11's controlled substance form for Pregabalin 150 MG capsule documented 18 tablets remaining. However, the blister packet had 17 tablets remaining. Employee #3 stated, I forgot to sign when I gave it. 3. Resident #10 was admitted to the facility on [DATE] with diagnoses that included: Conversion Disorder with Seizures or Convulsions, Chron's Disease, and Dementia. Review of the residents medical record revealed the following: A physician's order dated 04/09/23 that directed, Lacosamide oral tablet 200 MG, give 1 tablet by mouth two times a day for Seizure. A Quarterly MDS assessment dated [DATE] showed that facility staff coded: a BIMS summary score of 04, indicating severe cognitive impairment and received anticonvulsant medications. During a controlled substances reconciliation on unit 3 west on 02/26/26 at 12:20 PM with Employee #10 (Registered Nurse/RN), it was noted that Resident #10's controlled substance form for Lacosamide 200 MG documented 18 tablets remaining. However, the blister packet had 17 tablets remaining. Employee #10 stated, I am supposed to sign the narcotic sheet when I pull the medicine to give it to the resident. The evidence showed that Employee #3 and #10 failed to ensure controlled substances were reconciled as evidenced by not signing off controlled medication forms when medications were administered to Residents' #9, #11, and #10. During a face-to-face interview on 02/26/26 at 3:28 PM, the findings were brought to the attention of Employee #2 (Director of Nursing/DON). The employee acknowledged the findings and stated, I am going to follow up with those nurses. Cross Reference 22B DCMR Sec. 3224.3.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and staff interviews, for one (1) of 10 sampled residents, facility staff failed to follow its policy and procedures for controlled substance disposal for Resident #8's Lacosamide (anticonvulsant medication) 100 MG (milligrams) tablets.The findings included: Review of the facility's Discarding and Destroying Medications policy dated 12/09/25 documented in part:Disposal of controlled substances must take place immediately (no longer than three days) after discontinuation of use by the resident. Resident #8 was admitted to the facility on [DATE] with multiple diagnoses that included: Epilepsy, Acute Respiratory Failure and Dysphagia. Review of the resident's medical record showed the following: A physician's order dated 11/28/25 that directed, Lacosamide oral tablet 100 MG, give 1 tablet via PEG (percutaneous gastrostomy) -Tube two times a day for Seizure for 30 Days, 11/28/2025 to 12/28/2025. On 02/26/26 at 10:30 AM, Employee #1 (Administrator) provided the surveyor with document that listed all the residents in the facility that were currently prescribed and taking on Lacosamide. Resident #8 was not on that list. During a medication cart audit on unit 2 east on 02/26/26 at 12:10 PM with Employee #3 (LPN), it was noted that Resident #8 had 23 Lacosamide 100 MG tablets stored in the narcotic box. When asked why Resident #8's had Lacosamide tablets, Employee #3 stated, I don't know. He's not getting this medication. During a face-to-face interview on 02/26/26 at 3:28 PM, Employee #2 (Director of Nursing/DON) acknowledged the findings and stated, There should have been a cart audit that should've found and disposed of the medication the proper way. I am responsible for making sure that the unit managers get the cart audits done. Audits are supposed to be done at the beginning of each month. I'm not sure if one was done for January 2025. When asked if he was aware that Resident #8 still had Lacosamide 100 MG tablets still on hand despite the medication having been discontinued for 59 days, Employee #2 stated, No, The evidence showed that Resident #8's Lacosamide was discontinued on 12/28/25 and for 59 days, facility staff failed to dispose of the controlled substance as per their policy. Cross Reference 22B DCMR Sec. 3227.13

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards. Based on record review and staff interviews, facility staff failed to meet the State requirement of providing a minimum daily average of four and one tenth (4.1) hours of direct nursing care per resident per day on 02/22/26, when an Immediate Jeopardy was identified. The census on that day was 117.The findings included:A Facility Reported Incident (FRI), intake #2785968, received by the State Agency on 02/22/26 at 7:26 PM documented, On February 22, 2026 at approximately 3 AM, [Resident #5] was found in the doorway of his room with his trach dislodged. An investigation is underway.An Immediate Jeopardy (IJ-J) was identified at 42 CFR 483.24, Quality of Life, F678, Cardiopulmonary Resuscitation on February 25, 2026 at 3:40 PM.Review of the staffing showed that on 02/22/26, the facility's total direct care staffing level was at 4.0. The state requirement is a minimum of 4.1. During a face-to-face interview on 03/03/26 at 10:38 AM, Employee #8 (Staffing Coordinator) calculated the total direct care staff, acknowledged that the 4.1 requirement was not met and stated, The staffing has been pretty good. Some days we just can't get replacements for the people who call out.Cross Reference 22B DCMR Sec. 3211.5

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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 one (1) of ten (10) sampled residents, facility staff falsely documented that they administered medications to Resident #71.The findings included: Resident #71 was admitted to the facility on [DATE] with multiple diagnoses that included: Convulsions, Hypertension and Spastic Hemiplegia Affecting Left Dominant Side. Review of the resident's medical record revealed the following: A physician's order dated 07/02/24 that directed, Lacosamide oral tablet 200 MG (milligrams), give 1 tablet by mouth two times a day for Seizure precaution. A Quarterly Minimum Data Set (MDS) assessment dated [DATE] showed that facility staff coded: a Brief Interview for Mental Status (BIMS) summary score of 15, indicating intact cognitive status; no rejection of care behaviors; had an active diagnosis of Epilepsy, unspecified, intractable, with status Epilepticus; and received anticonvulsant medications. Review of the Resident #71's Lacosamide tablet 200 MG Controlled Drug Receipt/Record/Disposition Form dated 05/22/25 showed that the last available dose was administered on 06/06/25 at 10 PM by Employee #7 (Licensed Practical Nurse/LPN). The count documented 0 tablets remaining. Review of the Omnicell (automated medication and supply system) inventory for June 2025 showed that there were six (6) Lacosamide 200 mg tablets in stock and available in the facility. Review of the June 2025 Medication Administration Record (MAR) showed that Employee #7 documented a check mark and her initials to indicate that she administered Lacosamide 200 MG tablet to Resident #71 on 06/07/25 at 10 PM, 06/09/25 at 10 PM, and on 06/11/25 at 10 PM. However, there is no documented evidence that the Lacosamide tablets were taken out of the Omnicell or that the medication had been delivered from the pharmacy. A Facility Reported Incident (FRI), intake #231646, submitted online to the State Agency on 06/13/25 at 5:33 PM documented, On 6/12/2025 I was informed that a nurse taking care of [Resident #71] had signed off that she had administered his Lacosamide tab 200 mg anticonvulsant 6/7, 6/9, 6/11/2025 however when I reviewed the controlled drug disposition form the last dose was administered on 6/6/25. The nurse signed that the medication was administered but upon investigation the patient had not received the medication. The evidence showed that Employee #7 falsely documented that she administered Resident #71's Lacosamide 200 MG. During a face-to-face interview on 02/26/26 at 12:56 PM, Employee #1 (Administrator) and #2 (Director of Nursing/DON), they acknowledged the findings with the Employee #1 stating, The nurse (Employee #7) was fired because of the incident. All licensed nurses were provided with education on accurate documentation practices, controlled substances handling procedures and consequences of falsification of documents. The doctor should've been made aware of any missed medication doses, regardless of the reason. All licensed nurses have access to the Omnicell.