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	06/16/2026

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

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 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 one (1) of four (4) sampled residents, facility staff failed to ensure the accurate reconciliation of narcotic/controlled medications; and failed to ensure that the established system to enable the accurate reconciliation of all narcotic/controlled medications was followed. Resident #1. The findings included: The facility's Controlled Substances policy dated 12/09/25 documented in part:Nursing staff must court controlled medications at the end of each shift. The nurse going on duty and the nurse going off duty must make the count together. They must document and report any discrepancies to the Director of Nursing Services. Facility staff failed to ensure the accurate reconciliation of Resident #1's controlled medications.Resident #1 was admitted to the facility on [DATE] with multiple diagnoses that included: Metabolic Encephalopathy, Muscle Weakness and Chronic Kidney Disease. Review of the resident's medical record revealed the following: Physician's order dated 05/15/26 that directed, Oxycodone (narcotic pain medication) HCl (hydrochloride) capsule 5 MG (milligrams), give 1 tablet by mouth every 4 hours as needed (PRN) for moderate to severe pain; Acetaminophen (pain medication) tablet 325 MG, give 2 tablets by mouth every 4 hours as needed for pain, do not exceed 4 grams (GMs) in 24 hours; Gabapentin (pain medication) oral capsule, give 200 mg by mouth one time a day for pain. A Quarterly Minimum Data Set (MDS) assessment dated [DATE] showed that facility staff coded: a Brief Interview for Mental Status (BIMS) summary score of 10, indicating moderately impaired cognitive status; received scheduled pain medications in the last 5 days; did not receive any PRN pain medications in the last 5 days; resident had occasional pain or hurting in the last 5 days that she rated a 06 on a zero to ten scale, with zero being no pain and ten as the worst pain; and was ordered an opioid medication. A Facility Reported Incident (FRI), #3043356, submitted to the State Agency on 06/01/26 at 7:52 PM documented, Possible narcotics variance detected. Investigation initiated. A follow up to the FRI #3043356, submitted to the State Agency on 06/12/26 at 10:03 PM documented in part:Employee #6 (Licensed Practical Nurse/LPN) found the Oxycodone IR 5 mg tablet difficult to remove out of the pack. Upon further inspection of the pack, she discovered that back of the pack had been tampered with and taped closed with clear tape. The Oxycodone 5mg tablet had been replaced with Loratadine tablets which have a similar color, size, and shape to Oxycodone IR 5 mg. In total, five (5) tablets were noted missing. During a face-to-face interview on 06/16/26 at 12:02 PM with Employee #9 (LPN, signed off on 05/31/26 at 7 PM that the narcotic count was correct and there were no discrepancies), he stated, The process for narcotic count is to count and make sure that nothing has been tampered with and that the count is correct. Looking at the package from the front, everything looked fine and we both signed that the count is correct. Turning the blister packet over and inspecting it for any damage is not something we typically do. I don't recall if that was done that day. All the tablets were there, and I did not notice that anything was tampered with. During a telephone interview on 06/16/26 at 12:29 PM, Employee #6 stated, That morning (06/01/26), I went to do Resident #1's vitals and she complained of pain. When I went to go get the Oxycodone 5mg to give it to her, I realized it was hard to pop out. So, I turned the package to pop it from the back and that's (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

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	06/16/2026

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

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	when I saw that there was tape on it. There were five (5) spots with tape that looked like the pills had already been popped out and then taped back. I gave the resident PRN Acetaminophen and called the supervisor to report about what I found. When I did the count at the start of my shift (on 05/31/26 at 7 PM with Employee #9), I didn't pick up the mediation card to inspect it. I saw that the number of pills there was the same as on the sheet and so I signed off that it was correct. The evidence showed that facility staff failed to ensure the accurate reconciliation of Resident #1's controlled medications as evidence by Employees #6 and #9 not inspecting the medication blister pack during their narcotic reconciliation count on 05/31/26 at 7:00 PM. During a face-to-face interview on 06/16/26 at 12:53 PM, Employee #2 acknowledged the findings and stated that education has been started to ensure that all licensed nurses know the proper way to do the narcotic count. 2. Facility staff failed to ensure that the established system to enable the accurate reconciliation of all controlled medications was followed. During a narcotic reconciliation count on unit 3 west on 06/16/26 at 9:55 AM, Employee #4 (Licensed Practical Nurse/LPN) pulled out the narcotic logbook for medication cart #2. It was observed that he had not signed his name to indicate that the count was correct at the start of his shift at 7 AM. When asked why he did not sign off that the narcotic count was correct at the start of his shift with the outgoing nurse, Employee #4 stated, I must've forgotten. Review of the education record showed that Employee #4 completed the education on drug diversion/narcotic reconciliation on 06/01/26. The evidence showed that Employee #4 failed to ensure that the established system to enable the accurate reconciliation of all controlled medications was followed by not signing off with the outgoing nurse at the time that the narcotic reconciliation count was conducted. During a face-to-face interview on 06/16/26 at 12:53 PM, Employee #2 acknowledged the finding and made no comments. Cross Reference 22B DCMR Sec. 3224.3 (d)

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	06/16/2026

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

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 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop, implement, and/or maintain an effective training program for all new and existing staff members. Based on record review and staff interviews, facility staff failed to implement an effective training program for existing staff as evidenced by Employee #6 (Licensed Practical Nurse/LPN) working a shift after suspension without receiving education on drug diversion/narcotics reconciliation after she was involved in a reported incident of missing narcotics. The findings included: A Facility Reported Incident (FRI), #3043356, submitted to the State Agency on 06/01/26 at 7:52 PM documented, Possible narcotics variance detected. Investigation initiated. A follow up to the FRI #3043356, submitted to the State Agency on 06/12/26 at 10:03 PM documented in part:- Employee #6 found the Oxycodone (narcotic pain medication) IR 5 mg (milligrams) tablet difficult to remove out of the pack. Upon further inspection of the pack, she discovered that back of the pack had been tampered with and taped closed with clear tape. The Oxycodone 5mg tablet had been replaced with Loratadine tablets which have a similar color, size, and shape to Oxycodone IR 5 mg. - In total, five (5) tablets were noted missing tablets. - Employee #6 was suspended pending the outcome of investigation. Review of Employee #6's timecard showed that she returned from suspension and worked the night shift on 06/13/26 from 7:13 PM to 06/14/26 at 7:54 AM. Review of the education records provided to the surveyor on 06/16/26 at approximately 3:00 PM, showed no documented evidence that Employee #6 completed or received the education on drug diversion/narcotics reconciliation.During a face-to-face interview on 06/16/26 at 3:25 PM, Employee #2 (Director of Nursing/DON) and Employee #7 (Staff Development/Educator) acknowledged the finding. Employee #2 stated, The employee should have received the education prior to restarting work after her suspension.Cross Reference 22B DCMR Sec. 3214.1