

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 095024		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/08/2026	
NAME OF PROVIDER OR SUPPLIER Harborside Health & Rehabilitation				STREET ADDRESS, CITY, STATE, ZIP CODE 4601 MARTIN LUTHER KING JR AVENUE SW , WASHINGTON, District of Columbia, 20032			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0000	INITIAL COMMENTS An unannounced revisit survey was conducted at this facility from 09/04/26 to 09/08/26. This survey was a follow-up to the Facility Reported Incident Survey [#23676A-H1] of 06/16/2026. Survey activities consisted of observations, record reviews, and resident and staff interviews. The sample included five (5) residents. The facility's census on the day of the survey was 105 residents. After analysis of the findings, it was determined that the facility was in substantial compliance with the requirements of 42 Code of Federal Regulations (CFR) Part 483, Subpart B, and Requirements for Long-Term Care Facilities.			F0000			

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 reverse for further 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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