STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215033	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Levindale Hebrew Ger Ctr & Hsp	2434 West Belvedere Avenue Baltimore, MD 21215

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 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. Based on interview and record review it was determined that the facility failed to ensure allegations of abuse were timely reported. This was evident for 1(#211) out of 1 Resident reviewed for timely reporting of abuse allegations during the facility's recertification survey. The findings include: On 3/11/26 at 10:33AM the surveyor conducted a review of documented correspondence dated 11/17/25 at 3:12AM in which the following information (1-6) was included in communication from Resident #211 to Chief Administrative Officer (CAO) #37:1.) I will not be going to (Director of Nursing), The last time I did, s/he came into my room and yelled at me, While I am here, this hospital room is my home, I would never stand for someone yelling at me in my home, I will not stand for it here, I did not yell at (Director of Nursing) first.2.) The Administrator's conduct felt disrespectful to them.3.) Allegations which included the following information: S/he (Geriatric Nursing Assistant # 38) proceeded to yell at me. 4.) The following request for the facility to self report: I would like you to self report. 5.) An additional request for reporting: Please report (GNA #38) to the Board of Nursing.6.) Another request for the facility to self-report: Please self-report to CMS and do not retaliate.Further review by the surveyor on 3/11/26 at 10:33AM of documented correspondence dated 11/17/25 at 10:33PM from the facility's CAO #37 to Resident #211 revealed the following information was communicated in response to Resident #211's communication sent to them on 11/17/25 at 3:12AM: (Resident #211) Thank you for your e-mail and voicemail today, I apologize for what you have described below, I have included our culinary leaders for one of your primary concerns noted below, I will follow up with the leaders on the tech (GNA #38) you noted below and appropriate action will be taken, Sincerely, (CAO #37).On 3/11/26 at 10:45AM the surveyor conducted an interview of the facility's Administrator and requested for them to provide all self-reports made including to all agencies, and provide all investigation that occurred regarding Resident #211 at which time the Administrator reported to the surveyor that the facility had no knowledge of Resident #211's concern for abuse until a surveyor informed them on 2/5/26 which resulted in a self-report made at that time once aware.On 3/11/26 at 10:54AM the surveyor conducted an interview of the facility's Administrator who confirmed that the only reports made regarding Resident #211 was one initial report made to the Office of Health Care Quality (OHCQ) on 2/5/26 and one follow up report made to OHCQ on 2/12/26.On 3/11/26 at 12:05PM the surveyor conducted an interview of CAO #37 who informed the surveyor that Resident #211's care concerns were handled through the normal processes and when his/her concerns came in, they were investigated and unsubstantiated. When the surveyor inquired as to the initial timeframe that Resident #211's care concerns were brought to them by the Resident, CAO #37 reported that documentation was maintained by the facility Administrator, Patient Experience Leader #39 and Staff #40, and that everything goes through the patient experience department. CAO #37 reported to the surveyor that Resident #211 was discharged at the end of November 2025 and that they had received emails regarding care concerns prior to his/her departure and confirmed that they provided responses to the Resident by email and that there were multiple correspondence in which they dealt directly with Resident #211. The surveyor requested for all concern forms and all responses provided by the facility to be provided to this surveyor.On 3/11/26 at 12:46PM the surveyor conducted an interview of (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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the facility's Administrator in the presence of the survey team at which time the facility Administrator stated they had no knowledge of the allegations of abuse until surveyor notification in February of 2026. The Administrator stated to the survey team during the interview that the timeframe for reporting of an allegation of abuse was within two hours of the allegation being made. During the interview, the Administrator confirmed with this surveyor that all facility staff are responsible for timely reporting even if the allegation information does not reach them timely. The facility Administrator identified themself during the interview as the facility's abuse coordinator and stated: (Resident #211) did not want a grievance filed. This surveyor then inquired to the facility Administrator as to if the facility was reporting allegations of abuse received by facility staff in situations where Residents choose not to file a grievance. At this time, the Administrator confirmed that allegations of abuse would still need to be reported. At this time, the surveyor shared their concerns for abuse not being timely reported regarding the allegation of abuse made regarding GNA #38, and shared the concern that the allegation of abuse regarding the facility's DON had not been reported or investigated. The Administrator inquired to this surveyor as to what the abuse concern was regarding the DON at which time the surveyor referred them to review the correspondence documentation from Resident #211 dated 11/17/25 and CAO #37's correspondence documentation in response to the Resident on 11/17/25 which they had not provided to this surveyor. On 3/11/26 at 1:12PM the Administrator provided this surveyor with self-report email documentation dated as sent 3/11/26 at 1:10PM to OHCQ and reported that they were now beginning investigation of the allegation regarding the DON.Concerns were again reviewed during the facility's exit conference on 3/13/26 with the facility's Director of Nursing and Administrator. Reference to F610.