STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215071	A. Building B. Wing	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hebrew Home of Greater Washington	6121 Montrose Road Rockville, MD 20852

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 34484 Based on medical record review and interview, the facility staff failed to notify a resident's physician and/or responsible party for a change in status in a timely manner (Resident #630, #643). This was evident for 2 of 108 residents reviewed during a recertification/complaint survey. The findings include: 1) The facility staff failed to notify Resident #630's physician and responsible party for changes in the Resident's pressure ulcer. Review of Resident #630's medical record on 1/29/25 revealed on 3/20/23 the Resident was assessed to have a Stage II sacral pressure ulcer. Further review of Resident #630's medical record revealed on 3/30/23 the Resident was assessed by the Wound care doctor to have a Unstageable sacral pressure ulcer. A) Further review of Resident #630's medical record revealed the Wound care doctor saw the Resident weekly except for 4/20/23, 7/3/23, 7/10/23, 7/27/23, 8/3/23 and 8/17/23. On those dates there is no documentation in the medical record the facility staff reviewed the Resident's wound status with Staff #58 (Primary physician) to determine if the wound treatment needed to be changed. B) Review of Resident #630's wound care orders revealed the sacral pressure ulcer treatment was changed on the following dates: 4/27/23, 5/18/23, 5/25/23, 6/1/23, 6/8/23, 7/20/23 and 8/10/23. Further review of the medical record revealed no documentation that the facility staff notified the Resident's responsible party of the wound care order changes. Interview with the Director of Nursing #1 on 1/31/25 at 8:19 AM confirmed the facility staff failed to notify the Resident's primary physician of the sacral pressure ulcer assessments when the Wound care doctor was not available and failed to notify the Resident's responsible party when the Resident's sacral pressure ulcer wound treatment orders were changed. 2) The facility staff failed to notify Resident #643's physician timely when the Resident had a fall with injury on 6/13/24. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #643's medical record on 2/3/25 revealed the Resident had a fall on 6/13/24 at 5:45 PM with an initial neuro assessment at 5:45 PM. Further review of the Resident's medical record revealed notification of the fall was not sent to the doctor until 6/13/24 at 6:44 PM, 1 hour after the fall. The notification stated, patient was observed on the floor near the toilet and had injury on the right elbow with tunneling 2 cm by 1.2 cm by 1 cm, he/she also hit his/her head on the floor, no sign of hematoma present. Patient stated that his/her daughter is coming to take him/her to the hospital to get suture on elbow please advise. Further review of Resident #643's medical record revealed a hospital transfer note on 6/13/24 at 7:11 PM that stated, Patient was observed on the floor near the toilet and had injury on the right elbow with tunneling 2 cm by 1.2 cm by 1 cm, he/she also hit his/her head on the floor, no sign of hematoma present, and right hip. Gauze dressing apply Patient was seen by the shift supervisor and suture is needed for the right elbow, patient is transferred to the hospital for more assessment. Interview with Director of Nursing #1 on 2/4/25 at 8:00 AM confirmed the facility staff did not notify the Resident's physician until 1 hour after a fall with injury on 6/13/24.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 31145 Based on review of facility reported incidents with documentation and interview, it was determined the facility failed to report allegations of abuse, neglect, and injuries of unknown origin within 2 hours of the allegation to the regulatory agency, the Office of Health Care Quality (OHCQ). This was evident for 18 (#631, #647, #646, #627, #641, #637, #621, #5, #620, #250, #94, #229, #157, #96, #278, #264, #77, and #48) residents of 60 facility reported incidents reviewed during an annual and complaint survey. The findings include: 1) On 1/27/25 at 10:12 AM a review of facility reported incident MD00188273 revealed Resident #631 alleged that he/she was raped 5 nights prior by multiple guys. On 1/26/23 at 16:25 (4:25 PM) the daughter informed facility staff. The facility's investigation included an email confirmation as to when the initial report was sent to OHCQ. Review of the email confirmation documented the email was sent to OHCQ on 1/26/23 at 8:55 PM. This was not within 2 hours of the allegation. On 1/28/25 at 2:15 PM the facility reported incident was reviewed with the DON #1. The surveyor showed the DON #1 the initial email confirmation which documented the report was sent at 8:55 PM and was not within 2 hours of being informed. The DON #1 stated, oh it did not get sent within 2 hours. I will have to check into that. On 1/29/25 at 8:18 AM the DON #1 brought the abuse policy to the surveyor and stated they did not have to report within 2 hours unless there was an injury. The surveyor informed the DON #1 of the regulation. The DON #1 stated understanding, and they would have to change the way they report. 2) On 1/27/25 at 1:05 PM a review of facility reported incident MD00204909 revealed Resident #647 was found with skin discoloration/bruise to the right hip on 4/21/24 at 8:15 PM. The assigned geriatric nursing assistant (GNA) notified the charge nurse. The charge nurse notified the physician, the responsible party and the shift supervisor. The shift supervisor failed to immediately notify nursing administration or the facility's administrator. Nursing administration was not notified until 4/22/24 at 8:25 AM. Review of the email confirmation for the facility report to OHCQ documented that the initial report was not sent until 4/22/24 at 10:59 AM which was not within 2 hours of finding the injury of unknown origin. On 1/28/25 at 2:10 PM an interview was conducted with the Director of Nursing (DON #1) who confirmed that the incident was not reported within 2 hours. 3) On 1/27/25 at 2:01 PM a review of facility reported incident MD00201444 documented that on 1/9/24 at 11:48 AM staff from a radiology company reported to the facility that Resident #646 had rib fractures that were found during the completion of a CT scan. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's investigation failed to produce an email confirmation as to when the initial self-report was sent to OHCQ. Review of the facility's timeline documented that the initial self-report was not sent to OHCQ until 1/10/24 at 13:10 (1:10 PM). This was not within 2 hours of becoming aware of the fractures. On 2/4/25 at 7:47 AM an interview was conducted with the DON #1. The DON #1 stated they talked about it as a team first before sending it to OHCQ. She said they are changing their process to report first before they discuss as a team. 4) On 1/28/25 at 8:42 AM a review of facility reported incident MD00193732 revealed Resident #627 alleged that he/she had been assaulted by the GNAs on 6/25/23 at 6:00 AM. The investigation documented that the nursing shift supervisor was notified. The investigation documented that during the shift staff continued to monitor, encourage, and re-approach the resident several times to provide care but the resident was combative, refused care, bladder scanning, and fingerstick checks. Resident #627 continued to allege that he/she was still being abused, and that staff were holding the resident captive. The facility's investigation documented that the DON #1 and Assistant Director of Nursing (ADON) were not notified until 14:00 (2 PM). Review of the initial report email confirmation revealed the self-report was emailed to OHCQ on 6/25/23 at 4:13 PM. It was not reported within 2 hours of the resident reporting the alleged abuse. On 1/28/25 at 10:43 AM an interview was conducted with the DON #1 and the Clinical Risk Manager. The email confirmation was reviewed, and they acknowledged that the report was not submitted within 2 hours. On 1/29/25 at 8:18 AM the DON #1 brought the abuse policy and stated they did not have to report within 2 hours unless there was an injury. The surveyor was informed of the regulation. The DON #1 stated understanding and that they would have to change the way they report. 5) On 1/28/25 at 12:53 PM a review of facility reported incident MD00166270 was conducted and revealed on 4/16/21 Resident #641 was noted with swelling and discoloration to the left hand fourth finger with a complaint of pain. An x-ray was performed and revealed an acute fourth proximal phalanx fracture. The facility became aware of the x-ray result at 22:22 (10:22 PM). Review of the facility's investigation revealed an email confirmation that the initial self-report was sent to OHCQ on 4/16/21 at 11:00 PM. Further review of the facility's investigation revealed that on 4/16/21, GNA #41 documented, I gave resident shower in the morning. Did not notice any discoloration to finger on hand. During lunch I noticed a slight discoloration on [his/her] 4th finger on the left hand. I told another GNA. Meant to tell the charge nurse but forgot to because I was busy during the lunch period and after lunch. GNA #41 failed to immediately report the injury of unknown origin immediately to the charge nurse and/or nursing administration. On 2/4/25 at 2:26 PM the investigation was discussed with the DON #1 who confirmed the findings. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6) On 1/29/25 at 2:33 PM a review of facility reported incident MD00209039 was conducted and revealed Resident #637 alleged that a GNA who had taken care of the resident that morning was mean and rough. It was documented that Resident #637 stated, she was mean and rough to the point of being abusive. Review of the facility's investigation revealed the allegation was reported to staff on 8/21/24 at 15:57 PM (3:57 PM). The email confirmation to OHCQ documented that the initial report was sent on 8/22/24 at 11:57 AM, which was not within 2 hours of being reported to staff. Review of the 5-day report also documented that the initial self-report was not sent to OHCQ until 8/22/24 at 12:45 PM. On 2/3/25 at 8:17 AM an interview was conducted with the DON #1. The DON #1 confirmed that the report was not sent within 2 hours because the GNA had already left for the day, and they waited until the next day to send the report to OHCQ. The DON #1 stated, at the time since there were no injuries we did not realize we had to report within 2 hours. 7) On 2/3/25 at 8:00 AM a review of facility reported incident MD00208804 was conducted and revealed on 8/15/24 Resident #621 was noted to be grimacing when the right arm was lifted during morning care. An x-ray was done and revealed an acute fracture of the humerus. Review of the facility's investigation revealed the staff learned of the fracture on 8/15/24 at 4:37 PM. Review of the initial self-report failed to reveal an email confirmation as to when the initial self-report was submitted to OHCQ. On 2/4/25 at 9:47 AM the DON #1 was interviewed and stated, we were not getting a receipt. We were not checking the box to get a copy with the time the report was submitted. We will have to educate whoever is submitting the reports. 8) On 2/3/25 at 11:20 AM a review of facility reported incident MD00194070 was conducted and revealed Resident #5 alleged to his/her son that Resident #5 had been hit on the back and arm by staff during care. Review of the facility's investigation revealed the allegation was reported to staff on 7/4/23 at 16:00 (4 PM). The email confirmation to OHCQ documented that the initial report was sent in on 7/5/23 at 4:40 PM, which was not within 2 hours of being reported to staff. On 2/4/25 at 7:53 AM an interview was conducted with the DON who stated they talked about it as a team first before sending it to OHCQ. She said they are changing their process to report first before they discuss as a team. 9) On 2/3/25 at 11:46 AM a review of facility reported incident MD00209785 documented the Clinical Team Manager (CTM) received from the attending physician a message stating that Resident #620 reported to him about aggressive behavior towards the resident by two staff members. Review of the facility's investigation revealed the allegation was reported to staff on 9/12/24 at 14:47 (2:47 PM). The email confirmation to OHCQ documented that the initial report was sent on 9/13/24 at 9:31 AM, which was not within 2 hours of being reported to staff. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/4/25 at 7:47 AM an interview was conducted with the DON #1. The DON #1 stated they talked about it as a team first before sending it to OHCQ. She said they are changing their process to report first before they discuss as a team. 10) On 2/3/25 at 12:58 PM a review of facility reported incident MD00209392 documented that Resident #250 reported to Social Work on 9/2/24 at 11:18 AM that the assigned GNA hurt the resident's private area while cleaning during care and was inappropriate with the resident's private area. Review of the facility's investigation revealed the allegation was reported on 9/2/24 at 11:18 AM, however the email confirmation to OHCQ documented that the initial report was sent on 9/3/24 at 10:00 AM. On 2/4/25 at 7:47 AM an interview was conducted with the DON #1. The DON #1 stated they talked about it as a team first before sending it to OHCQ. She said they are changing their process to report first before they discuss as a team. 44441 11) On 1/28/25 at 1:30 PM, review of a facility reports MD00194158 had that Resident #94 told the activity assistant that s/he did not get enough sleep because their neighbor came to their room and was intimate with him/her, that they must keep it a secret as the spouse was away. Further review of the facility reports on 1/28/25 at 1:40 PM revealed that the resident had a history of severe Dementia and adjustment anxiety disorder. Their Brief interview for mental status (BIMS) score was 6/15 indicative of severe cognitive impairment. An interview with staff revealed that Resident #94 was alert and oriented to self only. S/he was confused, disoriented, and needed a lot of redirections, verbal cueing, and hand gesturing to support needs. Continuing review of the investigative report on 1/28/25 at 1:50 PM revealed that a thorough investigation was carried out. The residents' interviews and assessments, including staff interviews, were also obtained. The abuse allegation was reported to the police and appropriate authorities but was not substantiated. The recreational director received an email about this incident at about 1:17PM however, it did not get reported to the office of health care quality until 5:01PM which was about 4 hours later and more than 2 hours past the stipulated reporting window. On 1/28/25 at 2:00 PM in an interview with the Nursing House Administrator (NHA), he was asked to explain the abuse reporting process. He stated that an abuse should be reported within 2 hours from the time the facility was made aware of the incident. That the expectation is that the facility has a secure message system that includes the physician, executive director, Director of Nursing (DON #1), the clinical excellence team and SW including the actual reporting nurse and they talk about the case first. That most of the time the case will escalate, and they decide if its reportable or not, and then do the investigation. He was asked who was responsible for reporting the incident to the appropriate authorities and he said the reporting was done by Clinical excellence coordinator, NHA or Director of Nursing (DON #1). He was made aware that the incident was not reported timely, he confirmed that it wasn't. 42507 (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	12) On 1/29/2025 at 8:23 AM, review of the investigation report of Facility Reported Incident (FRI), MD00193835, revealed that Resident #229 reported to the bilingual Social Worker on 6/27/2023 at 3:19 PM that the brutish looking person twisted their hand and hit them. Further review of the investigation report of the FRI revealed that the initial self-report of the allegation of abuse was submitted to the State Survey Agency (OHCQ) on 6/27/2023 at 6:21 PM and the local police was notified on 6/27/2023 at 7:00 PM, more than 2 hours past the time the facility staff were made aware of the allegation. Thus, failing to meet the 2-hours reporting requirements for any allegation of abuse. On 1/29/2025 at 1:54 PM in an interview with the Nursing Home Administrator (NHA), the surveyor reviewed the time the facility reported the allegation of abuse to OHCQ and local law enforcement. NHA verified and confirmed that the facility failed to report an allegation of abuse within the required 2-hour window. On 2/7/2025 at 8:34 AM in an interview with the Director of Nursing (DON #2) prior to survey exit, Surveyor reviewed the above FRI with her. DON #2 was informed of surveyor's concerns regarding the facility's failure to timely report an allegation of abuse. No further information was provided. 13) On 1/30/2025 at 10:15 AM, a review of Facility Reported Incident (FRI), MD00192211, revealed that on 5/9/2023 at 11:20 AM, Resident #157 reported to the Violinist that they were raped by a man this morning. A review of the initial self-report revealed the facility notified the police on 5/9/2023 at 3:20 PM and sent the initial self-report to the State Survey Agency (OHCQ) on 5/9/2023 at 3:32 PM, more than 2 hours after facility staff were made aware of the allegation of rape (sexual abuse). Thus, failing to meet the 2-hour reporting requirements for any allegation of abuse. On 2/7/2025 at 8:38 AM, an interview was conducted with the Director of Nursing (DON #2): She reviewed and confirmed that the initial self-report of the above allegation of abuse was submitted to OHCQ on 5/9/2023 at 3:32 PM, more than 2 hours after facility staff were made aware. No additional information was provided. 50904 14) On 1/31/25 at 7:48 AM, the surveyor reviewed the facility's reported incident investigation packet on intake MD00207050, and it revealed that on 06/25/2024 at 2:45 PM, Resident #96 called 911 and reported that the unit secretary Staff #27 twisted his/her hands and pulled away the phone. On 06/25/2024 at 3:24 PM, Clinical Team Manager #3 notified the Director of Nursing (DON 1) and Assistant Director of Nursing #54. Resident Change Evaluator's note on 06/25/24 at 4:28 PM showed: Resident called 911 and reported Unit Secretary pulled away the phone from his/her hands and twisted his/her arms while he/she was sitting in the TV room. He/She called 911 and reported the incident. On 06/25/24 at 7:00 PM, the initial report was sent to the state agency (SA). (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/03/25 at 08:11 AM, in an interview with the DON 2, when she was asked what the reporting time for an allegation of abuse was, she stated that allegations of abuse should be reported within two hours. She was informed about the reporting time for the incident, and she verbalized that it was past 2 hours of reporting an allegation of abuse. 15) On 02/03/2025 at 7:29 AM, the surveyor reviewed the facility's reported incident investigation packet on intake MD00193633, and it revealed that, on 06/20/2023 at 2:21PM, Resident #278 had reported to the Clinical Team Manager #53 that CNA #52 who had him/her the previous night was very rude, did not help him/her position his/her legs, told the resident he/she was too demanding and did not want to hear his/her call light for the next three hours. Spoke down on him/her and was in tears. On 06/20/2023 at 3:29 PM, Director of Nursing (DON 1) and Assistant Director of Nursing were made aware. On 06/21/2023 at 10:06 AM, the matter was reported to the state agency (SA). On 02/03/25 at 08:11 AM, in an interview with the DON 2, when she was asked what the reporting time for an allegation of abuse was, she stated that allegations of abuse should be reported within two hours. She was informed about the reporting time for the incident, and she verbalized that it was past 2 hours of reporting an allegation of abuse. 51213 16) On 1/31/2025 at 01:10 PM the Director of Nursing (DON #1) was shown some notes from the facility reported incident and was asked if these notes were from their internal risk management system? DON #1 replied, yes, these notes are from our internal risk management system and are available upon request. DON #1 was then asked if the facility filed the self-report MD#00209782 to the Office of Healthcare Quality (OHCQ) on 9/12/2024 at 5:18PM? DON #1 replied, yes we reported this incident to OHCQ on 9/12/2024 at 5:18 PM. DON# 1 was then shown that their internal risk management report and the self-report sent to OHCQ documented stated that resident #264 reported an allegation of abuse to a Social Worker, Staff # 62 at 12:33 PM on 9/12/2024. DON #1 was notified of the alleged abuse at 12:46 PM on 9/12/2024, and the facility incident report was sent to OHCQ on 9/12/2024 at 5:18PM. DON #1 was then asked what time frame should an allegation of abuse be reported to OHCQ? DON #1 replied within two hours. DON #1 was then asked if this incident MD#00209782 was reported within two hours. DON #1 replied no it was not. 51789 17) On 2/4/2025 at 11:25 AM, the Surveyor reviewed a facility-reported incident, MD00206760. It was revealed that on 6/17/2024 at 2:45 PM, Resident # 77 reported that his/her left middle finger was bruised and painful because a resident pushed a walker to his/ her and hit the left middle finger. Further review of the facility's investigation revealed that the facility submitted the incident's initial report to OHCQ (Office of Health Care Quality) on 06/17/2024 at 6:20 PM, 4 hours later upon learning of the incident. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. 31145 Based on review of facility reported incidents and staff interview, it was determined the facility failed to provide documentation that allegations of abuse were thoroughly investigated. This was evident for 9 (#629, #638, #640, #366, #625, #5, #622, #87, and #619) residents of 60 facility reported incidents reviewed during a recertification/complaint survey. The findings include: The Minimum Dats Set (MDS) is a standardized and comprehensive assessment screening tool used to identify resident's individual needs and areas of concern. BIMS stands for Brief Interview for Mental Status. It is a screening tool used to assist with identifying a resident's current cognition and to help determine if any interventions need to occur. 1) On 1/28/25 at 11:30 AM a review of facility reported incident MD00167904 was conducted and revealed a Clinical Team Manager received an email on 5/31/21 that stated on 5/30/21 around 2pm, Resident #629 complained to a musical therapist that he/she was raped 3 weeks ago. Review of the facility's investigation revealed that 36 staff were interviewed, however there were no resident interviews from the unit where Resident #629 resided. On 2/3/25 at 2:15 PM an interview was conducted with the DON #1. The DON confirmed that there was no resident interviews found in the investigative packet given to the surveyor. 2) On 1/29/25 at 8:10 AM a review of facility reported incident MD00195669 was conducted and revealed Resident #638 alleged that someone had punched the resident 3 times in the face the night before. Review of the facility's investigative packet that was given to the surveyor on 1/29/25 revealed there were (9) staff members that had worked with the resident that were interviewed. There were no resident interviews from residents that resided on the same unit to ask if they felt safe or had any abuse concerns with staff members. On 1/29/25 at 12:11 PM an interview was conducted with the Director of Nursing (DON #1). The DON #1 checked to see if the social worker had emailed resident interviews for the intake and confirmed that she did not have any resident interviews. 3) On 1/29/25 at 11:00 AM a review of facility reported incident MD00194021 was conducted and revealed Resident #640 alleged that a GNA was very rough when cleaning the resident during incontinence care. A review of the facility's investigation revealed an interview with the accused GNA along with a background check from the agency that the GNA was contracted from. There were no resident interviews from the agency GNA's assignment included in the investigation. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/29/25 at 12:11 PM an interview was conducted with the DON #1. The DON #1 checked to see if the social worker had emailed resident interviews for the intake and confirmed that she did not have any resident interviews. The DON confirmed it was an incomplete investigation. 4) On 1/29/25 at 11:49 AM a review of facility reported incident MD00206126 was conducted and revealed during the night shift on 5/26/24 Resident #366 alleged that a tall man came into the resident's room and changed the resident's diaper, and the resident stated he/she did not wear a diaper. Review of the facility's investigation revealed a written statement from the agency geriatric nursing assistant (GNA) and (7) resident interviews, however there were no other staff interviews included in the investigation. On 2/3/25 at 8:11 AM an interview was conducted with the DON #1. The DON #1 confirmed that there were no other staff interviews. The DON #1 stated, the agency GNA was interviewed and another GNA from our staff. The Social Worker stated that she interviewed others but there was no documentation. 5) On 2/3/25 at 10:15 AM a review of facility reported incident was conducted and revealed Resident #625's family member alleged that Resident #625 had been slapped on 3/2/23 and 3/3/23 by staff. Review of the facility's investigation revealed that 16 staff members were interviewed, however there were no other residents on the unit that were interviewed. On 2/4/25 at 7:45 AM the DON #1 was interviewed and confirmed there were no other resident interviews from the GNA's assignment. 6) On 2/3/25 at 11:20 AM a review of facility reported incident MD00194070 was conducted and revealed Resident #5 alleged to his/her son that Resident #5 had been hit on the back and arm by staff during care. Review of the facility's investigation revealed a statement from the GNA that was taking care of Resident #5, however there were no other staff interviews included in the investigation. On 2/4/25 at 9:57 AM an interview was conducted with the DON #1. The DON #1 confirmed that they did not have any other documented interviews of staff. 7) On 2/4/25 at 8:50 AM a report of facility reported incident MD00182370 was conducted and revealed Resident #622 alleged that he/she was sexually assaulted the previous evening on 2/10/22. A review of the facility's investigation revealed staff were interviewed but there were no other residents on the unit that were interviewed. On 2/4/25 at 9:57 AM an interview was conducted with the DON #1. The DON #1 confirmed that they did not have any other documented interviews of residents on the unit. 43096 (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8) During an investigation of the facility self-reported incident, MD00206059, on 1/28/25 at 8:25 AM, it revealed that Resident #87 reported on 5/26/24 that a Geriatric Nursing Aide (GNA #57) who was assigned to him/her violated the resident's rights, including turning off the call light, leaving the room, and not asking what the resident needed when they provided care to Resident #87. Further review of the facility's investigation regarding this report showed that the facility conducted a phone interview with GNA #57 and resident interviews, including Resident #87 and other residents. However, the facility did not have interviews with other staff to support their thorough investigation. In an interview with the Director of Nursing (DON #1) on 1/28/25 at 11:04 AM, she stated that the facility interviewed residents, perpetrators, and other staff while they were investigating the resident's abuse case. The surveyor reviewed Resident #87's abuse case with the DON. She said, I will search for other staff interviews for this case. On 1/30/25 at 2:41 PM, the DON #1 confirmed that the facility could not find other staff interviews for this reported incident. She validated the surveyor's concern that this investigation was not thoroughly performed. 44441 9) On 2/4/25 at 9:00 AM, review of incident #MD00181518 had that Resident #619 told a family member who reported to the charge nurse, that, a male Geriatric Nursing Assistant (GNA) who gave resident a bath in the morning fondled their breast. The charge nurse reported the incident to the Clinical Team Manager. Review of Resident #619's MDS Section C (Cognition) on 2/4/25 at 9:15 AM with Assessment Reference Date (ARD) of 7/8/22 documented a BIMS score of 99 indicating that resident was unable to complete the interview. Review of the mental status assessment form, Section C1000 dated 7/7/22 documented that resident was severely impaired. The Resident also has a care plan for impaired cognitive function. Review of the investigative report done by the facility on 2/4/25 at 9:30 AM revealed that a thorough investigation was not conducted. The resident was assessed and no issues found except for old bruises from prior falls. The alleged staff member was immediately suspended and investigation started. The police, ombudsmen and the office of Health Care Quality (OHCQ) immediately notified. The resident, staff, and witness interviews were also obtained however, other resident's interviews could not be found. On 2/4/25 at 9:50 AM in an Interviews with the Director of Nursing (DON #1) she was made aware that other resident interviews could not be found and asked to verify. She checked the investigative report folder but could not find the missing document. She stated that if it's not in the folder, then it was not done. She was made aware that this was a concern.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 50904 Based on review of resident medical records and interviews with resident and facility staff, it was determined that the facility failed 1) to involve/invite a resident who had the capacity, to attend his/her own care plan meetings, and 2) to revise the resident's care plan after the resident developed a stage 2 sacral pressure ulcer. This was evident for 2 residents (Resident #96 and #963) out of 4 residents reviewed for care plan during the Medicaid/Medicare recertification/complaint survey. The findings include: 1) On 01/28/25 at 10:47 AM, during the initial screening of Resident #96, when he/she was asked if he/she or someone that he/she had appointed, had been to meetings where his/her own plan of care care was discussed, he/she stated that he/she has never attended one because nobody ever told him/her about any meeting. On 01/29/25 at 09:32 AM, the surveyor reviewed the electronic health records of the resident revealed that Resident #96's Brief Interview for Mental Status (BIMS) score for all quarters in 2024 was 15.0 out 0f 15.0. It also revealed that Resident #96 did not attend the care plan meetings for the last 3 quarters in 2024, and there was no documentation showing that the resident had attended the meeting or the reason why the resident did not attend the care plan meetings. On 01/29/25 at 11:07 AM, in an interview with the Director of Social Work #5 when she was asked why Resident #96 was not included in his/her care plan meetings, she stated that the resident had his/her own issues and most times he/she declined to go to the meeting. She also added that there was always a note in the progress note to indicate resident's attendance and refusals. Director of Social Work #5 also informed the surveyor that she spoke with one of the social workers covering the building (via the phone) and stated that the person had told her that Resident #96 was agitated and could not attend the care plan meetings. 01/29/25 11:26 AM, the surveyor reviewed Resident #96's electronic health record with the Director of Social Work #5, there was no documentation seen. The Director of Social Work #5 also confirmed that there was neither documentation stating if the resident was invited to the care plan meetings nor documentation of the resident's reason for not attending the care plan meetings in the record. On 01/29/25 at 11:38 AM, the Director of Social Work informed the surveyor that she wanted to check in with the social worker in charge of the building to see if there was any other documentation somewhere. At 11:58 AM, she informed the surveyor that there was no further documentation as it was not documented and that going forward, they would always document the residents' participation and reasons if the resident was not available. 01/29/25 02:07 PM, The Nursing Home Administrator was informed about the findings. 51128 (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) On 2/4/2025, at 11:01 AM, a record review of Resident #963 noted that a care plan was initiated on 08/20/2024 on admission to the facility with a revision date of 9/15/2024, and a target date of 11/19/2024. A further record check revealed Staff #32 wrote a progress note on 8/20/2024 at 7:55 PM, stating that Resident #963, Condition of skin is normal with no pressure injury identified on admission.Additional record review on 2/4/2025 at 11:15 revealed a change in condition note dated 8/25/2024 at 11:42 by staff # 68 that stated, While doing morning care, the patient was noted with a stage 2 pressure ulcer on his sacrum area. The dressing was done using solosite gel, the resident denied any pain, and the provider was notified. On 2/4/2025 at 12:43 PM, an interview was conducted with staff # 32, who stated that care plans should be updated by the nurse or unit manager when there was a change in condition such as a wound. In an interview with the Director of Nursing (DON #1) on 2/4/2025 at 1:43 PM, the surveyor reviewed Resident #963's care plan with the DON #1. She verified that the care plan was not updated after the discovery of the stage 2 sacral pressure ulcer on 8/25/2024.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. 31145 Based on review of a complaint, medical record review, and interview, it was determined the facility failed to ensure that a resident who required assistance received showers twice per week. This was evident for 1 (#636) of 30 residents reviewed for complaints during a recertification/complaint survey. The findings include: On 1/30/25 at 9:16 AM a review of complaint MD00195642 revealed an allegation that Resident #636, hardly ever got a bath. Review of Resident #636's medical record revealed the resident was admitted to the facility in December 2022 from an acute care hospital for rehabilitation and strengthening. Review of the 12/24/22 admission MDS documented that the resident required physical help related to bathing. Review of the shower log indicated that the resident was supposed to receive a shower twice per week on Monday and Thursday. Review of the GNA Documentation Report for January 2023 revealed blank spaces for every Monday and Thursday in January, which were 1/2/23, 1/5, 1/9, 1/12, 1/16, 1/19, 1/23, and 1/26/23. On 1/31/25 at 9:00 AM an interview was conducted with the Director of Nursing (DON #1). The surveyor reviewed the shower log with the DON #1. The DON #1 confirmed that the shower log was not filled out and stated that the geriatric nursing assistants (GNAs) should have documented if the resident refused showers or if the resident received the showers.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 34484 Based on facility reported incident and complaint, medical record review and interview, it was determined the facility failed 1) to provide care to meet the needs of a resident's physical, mental, and psychosocial health, 2) to ensure that residents receive treatment and care to promote the highest practicable wellbeing as evidenced by failures to consistently assess a resident for pain and failures to follow physician orders timely, and 3) to acquire a patient's medication to be administered thereby causing a delay in treatment. This was evident for 3 (Resident #131, #614, and #913) of 108 residents reviewed during a recertification/complaint survey. The findings include: 1) The facility staff failed to properly perform neuro checks after a fall for Resident #614. A neuro check after a fall refers to a neurological assessment performed by a healthcare professional to evaluate potential brain injuries by checking a person's level of consciousness, orientation, pupil response, muscle strength, sensation, and coordination. Review of the facility's 72 hour assessment protocol provided by DON #1 revealed the facility staff are to complete neuro checks at initial assessment, every 15 minutes X 4, then every hour X 3, then every 2 hours X 4, then every 4 hours X 3, then every shift for 48 hours. Review of Resident #614's medical record on 1/31/25 revealed the Resident had 2 falls on 8/4/24. The first fall was at 3:15 PM and the second fall was at 6:30 PM. Review of a nurse's note on 8/4/24 at 3:15 PM revealed the facility staff documented, Staff heard a loud bang noise turned around and observed resident on the floor by the bench in the hallway rubbing the right side of his/her head. Further review of Resident #614's medical record revealed after the first fall on 8/4/24 the facility staff did the initial assessment 8/4/24 at 3:15 PM, then neuro checks at 3:30 PM, 3:45 PM, 4:00 PM and then not again until 6:10 PM. The facility staff failed to do the last 15 minute neuro check at 4:15 PM and the hourly neuro check at 5:15 PM. Review of a nurse's note on 8/4/24 at 6:30 PM revealed the facility staff documented, Resident had another fall at 6:30 PM while ambulating with his/her walker. Further review of Resident #614's medical record revealed after the second fall on 8/4/24 the facility staff did the initial assessment 8/4/24 at 6:30 PM and not again until 7:30 PM. The facility staff failed to restart the 72 hour assessment protocol after the 2nd fall and do neuro checks every 15 minutes at 6:45 PM, 7:00 PM and 7:15 PM. The facility staff failed to do the hourly neuro checks at 8:30 PM, 9:30 PM and 10:30 PM. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Director of Nursing #1 on 1/31/25 at 9:35 AM confirmed the facility staff failed to complete neuro checks for Resident #614 on 8/4/24 per facility protocol. 42507 2) On 2/3/2025 at 11:04 AM, a review of the investigation report of Facility Reported Incident (FRI) MD00212905, revealed that on 12/15/2024 around 20:00 (8:00 PM) Resident #131's daughter spoke to the charge nurse and requested to have Certified Registered Nurse Practitioner (CRNP)/MD (Medical Doctor) assess the resident's left hand due to soreness. The charge nurse assessed Resident #131's left hand and there were no bruises, discoloration nor swelling noted per documentation. Pain medication was administered as Resident #131 was on routine pain medication and pain scale was at 0/10. Charge nurse sent a secure message on 12/16/2024 at 7:12 AM and again at 7:16 AM to the clinical team regarding Resident #131's daughter's request. Per the report, on 12/16/2024 at 11:00, CRNP visited with Resident #131 regarding the report of left hand soreness and gave an order for Occupational therapy (OT) evaluation as no soreness was noted. However, OT did not see the resident until 12/21/2024, as reflected in an Occupational Therapy (OT) Treatment Encounter Notes dated 12/21/2024: Pt is a LTC (long term care) resident here at SK. Pt. was referred to OT skilled services secondary to discomfort on left hand and decreased ROM (range of motion). Patient referred to OT due to exacerbation of decrease in range of motion indicating the need for OT to improve motor control/tone in UE (upper extremity) and facilitate tone in UE. Medical chart reviewed and OT evaluation was completed Thus, OT failed to see and evaluate Resident #131 in a timely manner and failed to address Resident #131's left arm fracture revealed by XRAY done that morning of 12/21/2024. Further review of the report revealed that On 12/20/2024 at 17:30 (5:30 PM), Geriatric Nursing Assistant (GNA) reported to charge nurse that Resident #131was screaming for pain when their left arm was lifted. Charge nurse conducted an assessment of Resident #131 and confirmed that the resident screamed when their arm was lifted. Charge nurse notified CRNP who gave an order for a stat XRAY of the resident's left arm and wrist to rule out fracture. The XRAY was done on 12/21/2024 at 5:00 AM and on 12/21/2024 at 7:50 AM, facility staff received the XRAY results that revealed Acute fracture at the greater tuberosity with lateral displacement. Diffused Osteopenia. Mild DJD at the left shoulder without discoloration. 0n 12/21/2024 at 8:36 AM, CRNP was made aware of the XRAY report and new orders given for pain med x two days, orthopedic consult for left humerus fracture, and immobilize left arm. However, a review of Resident #131's medical records revealed that the resident did not have the orthopedic consult done until 12/23/2024 when the resident was sent to the ER via 911 where they further confirmed an acute left arm fracture. On 2/04/2025 at 9:57 AM, in an interview with the Director of Nursing (DON #2), surveyor reviewed the timeline of events, staff assessment of pain, and delay in scheduling/providing ordered consults/treatment. DON #2 stated that the Charge Nurse heard left hand soreness and focused her assessment on the resident's left hand. DON #2 confirmed that staff assessment was not consistent and stated that the staff should have assessed Resident #131's entire arm when the resident's daughter requested it, as that was an opportunity to do a full assessment of the resident. Regarding the gap between when Resident #131's daughter requested an assessment (12/15/2024) to when an XRAY was ordered/done (12/21/2024), DON #2 stated that the Nurse Manager had requested on 12/16/2024 via secured message that an XRAY of the left arm be done but the CRNP requested that staff continue to assess and OT to see and evaluate Resident #131. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/4/2025 at 12:18 PM, an interview was conducted with the 3 East Clinical Team Manager (CTM #31). CTM #31 confirmed that Resident #131's daughter had told staff during care conference on 12/16/2024 that the resident had left arm pain. CTM #31 stated that she did an assessment of the resident and found out that Resident #131was in pain when the left arm was lifted (resident made a sound) but she (CTM #31) did not observe any swelling and/or discoloration to the resident's arm. CTM #131 stated that she then asked Resident #131's assigned Licensed Practical Nurse (LPN #11) to send a secure message and request an order for an XRAY. However, CTM #31 stated that the request was made but the CRNP (Certified Registered Nurse Practitioner) did not want to do an XRAY and ordered OT to see Resident #131. Regarding resident assessments, CTM #31 stated that the expectation was that when a nurse goes to do an assessment of a resident, it should be thorough (head-to-toe). CTM #131 confirmed that the assessment done by the Charge Nurse on 12/15/2024 when Resident #131's daughter first requested an assessment of the resident's pain was not thorough. On 2/4/2025 at 1:26 PM, in an interview with the Program Director for Rehab (Staff #7), he confirmed that Resident #131 had an OT evaluation completed on 12/21/2024 at 3:48 PM by a part time (PRN) Occupational Therapist (OT #37), five (5) days after the CRNP gave the order for OT to see and evaluate the resident. On 2/4/2025 at 1:32 PM, a phone interview was conducted with Occupational Therapist (OT #37). Regarding the delay in seeing Resident #131 for OT evaluation as ordered, OT #37 stated that she got an order to see Resident #131 on 12/18/2024 but their system was down and so the resident was rescheduled to be seen on 12/21/2024 by the Therapy Scheduler. OT #37 stated that the referral was for left arm pain. She further stated that when she went in to see Resident #131on 12/21/2024, the resident was lying in bed comfortable and had bilateral hand contractures. OT #37 stated that she did not see the XRAY results that indicated the resident had a left arm fracture prior to going in to evaluate the resident: OT #37 stated that her evaluation of Resident #131 comprised of assessing both hands for range of motion (ROM) and contracture management. On 2/7/2025 at 8:29 AM, in a follow up interview with DON #2, she was made aware of surveyor's concerns regarding staff assessment of Resident #131's pain not being consistent, OT not seeing the resident in a timely manner, and delay in sending the resident out for orthopedic evaluation and proper management of the resident's left arm fracture. Based on when Resident #131 first began experiencing pain, it was determined that the facility staff failed to properly assess the resident, delayed in obtaining an X-ray of the resident's left arm and sending the resident out for orthopedic management of their left arm fracture. DON #2 confirmed surveyor's findings and stated they identified opportunities for improvement and have re-educated staff on those areas. 50904 3) On 02/03/2025 at 12:53 PM, the surveyor reviewed intake number MD00198273, and it showed that the complainant had alleged the facility failed to acquire Resident #913's antibiotic medication to be administered upon his/her admission and he/she went for 2 days without receiving them. At 1:12 PM, the surveyor reviewed the electronic health record of Resident #913, and it revealed the following: a) The Nursing Progress note on 7/15/2023 at 09:00 PM showed- Resident #913 is a new admit to facility from the hospital. The resident is alert and oriented X 3, able to make his/her needs known. The resident is admitted for rehab to continue with his/her antibiotics (ABT) therapy for endocarditis. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b) The Electronic Medication Administration record note on 7/15/2023 at 11:52 PM showed -Daptomycin Intravenous Solution Reconstituted 500 MG. Use 500 mg intravenously every 48 hours for endocarditis until 08/23/2023 at 11:59 PM. Daptomycin start date 7/16/23 at 6:00 PM, last administered at the hospital 7/14/23. c) The Electronic Medication Administration record note on 7/16/2023 at 7:15 PM showed- Daptomycin Intravenous Solution Reconstituted 500 MG. Use 500 mg intravenously every 48 hours for endocarditis until 08/23/2023 11:59 PM. IV Pharmacy called and stated they are reconstituting the solution and will be delivered. The oncoming nurse was made aware. d) On 07/17/2023 at 00:25 AM, RN #59 sent a secured message to the Physician, Staff #60 stating Good morning Doctor. Patient #913 is a new admit yesterday, he/she was supposed to have his/her IV Daptomycin 500mg yesterday at 6pm, the order states after every 48 hours and yesterday it was due. But unfortunately, it was not delivered by the pharmacy. Just got to them now and they say it will be delivered today at 2:30 AM. Could we reschedule the administration for today at 6pm. At 07:48 AM, the physician responded positively. e) The Electronic Medication Administration record note on 7/15/2023 at 11:52 PM showed that Daptomycin Intravenous Solution Reconstituted 500 MG was given on 07/17/2023 at 2:54PM. On 02/04/2025 at 7:30 AM, in an interview with the Clinical Team Manager of 2 West, Staff #19, when she was asked about the antibiotic treatment for Resident #913, she stated that the resident came in from admission on a Saturday evening (07/15/2023) and was supposed to get two antibiotics (Cefepime and Daptomycin). She stated that the resident was to commence Daptomycin Intravenous Solution Reconstituted 500 MG on 07/16/23 at 6:00 PM and every 48 hours. She stated that multiple calls were made to the pharmacy on 07/16/2023 but the medication was not sent to the facility, but the other antibiotic (cefepime) was given as scheduled because it was available in the facility. She also added that Daptomycin Intravenous Solution Reconstituted 500 MG was eventually sent on 07/17/2023 and a one-time dose was given at around noon per the Doctor's recommendation. On 02/04/2025 at 8:17 AM, Director of Nursing (DON #2) and Clinical Team Manager of 2 West, Staff #19 were both informed about the time Daptomycin Intravenous Solution Reconstituted 500 MG was ordered and the time it was given and they both agreed that the treatment was delayed.

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Hebrew Home of Greater Washington	6121 Montrose Road Rockville, MD 20852

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34484 Based on investigating complaints, medical record review and interview, it was determined that the facility staff failed to provide treatment/services to prevent/heal pressures ulcers (Resident #630 and #660). This is evident for 2 of 4 residents reviewed for pressure ulcers during the recertification/complaint survey. The findings included: A pressure ulcer also known as pressure sore or decubitus ulcer is any lesion caused by unrelieved pressure that results in damage to the underlying tissue. Pressure ulcers are staged according the their severity from Stage I (area of persistent redness), Stage II (superficial loss of skin such as an abrasion, blister or shallow crater), Stage III (full thickness skin loss involving damage to subcutaneous tissue presenting as a deep crater), Stage IV (full thickness skin loss with extensive damage to muscle, bone or tendon) or Unstageable Pressure Ulcer (full thickness tissue loss in which the base of the ulcer is covered by slough and / or eschar in the wound bed). 1)Review of Resident #630's medical record on 1/29/25 revealed on 3/20/23 the Resident was assessed to have a Stage II sacral pressure ulcer, the physician was notified and treatment began. Further review of Resident #630's medical record revealed the facility staff failed to do a weekly skin assessment on the Resident to include measurements of the sacral pressure ulcer on the following dates: 3/27/23, 7/3/23 and 7/10/23. The Resident did not have a skin assessment from 6/26/23 until 7/13/23, or 17 days. Interview with the Director of Nursing #1 on 1/31/25 at 8:19 AM confirmed the facility staff failed to do weekly skin assessments to include measurements on Resident #630's sacral pressure ulcer on 3/27/23, 7/3/23 and 7/10/23. 43096 2)During an investigation of the facility's self-reported incident, MD00208505, on 2/03/25 at 9:27 AM, it was revealed that Resident #660's family members were concerned about the worsening pressure ulcers. Further review of Resident #660's medical record revealed that the resident's admission assessment dated [DATE] documented that he/she had a stage II pressure ulcer on the Right buttock upon admission. The facility's weekly pressure injury notes dated 5/09/24 listed Right buttock abrasion, sacrum, and Left buttock and mentioned that the wound doctor saw those wounds. Weekly pressure injury notes documented on 5/12/24, 5/19/24, and 5/27/24 as below: - Right buttock: stage I pressure ulcer measured (3cm x 3cm x 0, Length x Wild x Deep) on 5/12/24, stage II measured (3 x 4 x 0.1) on 5/19/24. - Left buttock: stage I pressure ulcer (3 x 2 x 0) on 5/12/24, and stage II on 5/19/24 with measured size (3 x 2 x 0). (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- sacrum: stage I on 5/12/24 measured (2 x 1 x 0), stage II measured (3 x 1 x 0.1) on 5/19/24 , and deep tissue injury on 5/27/24 sized (10 x 10 x 0.1). The review of Resident #660's Treatment Administration Record (TAR) and order on 2/03/25 at 10:50 AM revealed that the resident had an order to 'apply dermaceptin on Right and Left buttocks every change, every shift for bilateral buttocks excoriation and redness starting on 5/04/24 at 7 AM'; there were no additional orders regarding his/her wound care. A review of Resident #660's wound consultant documentation on 2/03/25 at 11:30 AM revealed that the resident was seen by a wound doctor (Staff #46) on 5/09/24. Staff #46 documented the sacrum wound as excoriation intermittent small open area noted. with an order of moisture barrier to the site to prevent further breakdown of denuded skin. Staff #46 evaluated the resident again on 5/23/24 and documented that sacrum wound excoriation was resolved. There were no new orders of 5/23/24. The following wound consultant's note was on 5/30/24 by Staff #46, which documented that Resident #660 had a deep tissue injury noted on his/her sacrum. However, there were no additional notes/orders/evaluations regarding Resident #660's worsening wound, even though Staff #46's consultation notes dated 5/23/24 and the facility's weekly wound note dated 5/19/24 had discrepancies regarding the wound's status. In a phone interview with the Director of Nursing (DON #1) on 2/03/25 at 1:46 PM, she confirmed that the wound consultant visited at least once a week and documented their notes in the facility's cloud medical records system. The surveyor informed DON #1 that Resident #660's wound consultant notes were not updated weekly when the resident's wound worsened. The DON #1 stated that she would look more for the documentation. On 2/06/24 at 10:36 AM, DON #1 was interviewed via phone. DON #1 confirmed that there was no additional documentation to support Staff #46 evaluating Resident #660 while his/her wound worsened. She stated that when the facility staff noted residents' condition changes, they should notify attending physicians and get a new order. During a phone interview with a wound doctor (Staff #46) on 2/06/25 at 12:05 PM, he stated that the wound care order should be changed depending on the condition of the wound. He explained that stages I to II might require changing the order. Staff #46 recalled Resident #660's wound condition and added that based on the resident's new diagnosis starting on 5/27/24, his/her overall condition was worsening. It affected the residents' wounds rapidly. Staff #46 reviewed his consultant notes and validated that following-up assessments were missing, and there were no order changes when the resident had worsening wounds. During an exit conference with the facility on 2/07/25 at 12:30 PM, the surveyor shared the above concerns with the facility administrator and the DONs.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 43096 Based on review of resident medical records and interview with facility staff, it was determined that the facility failed to address appropriate care when a resident had weight loss. This was evident for 1 (Resident #660) of 4 residents reviewed for nutrition during this recertificate survey. The findings include: During an investigation of the facility's self-reported incident, MD00208505, on 2/03/25 at 9:27 AM, it was revealed that Resident #660's family members were concerned about the resident's significant weight loss. The surveyor reviewed Resident #660's medical records on 2/03/25 at 9:40 AM; the review revealed that the resident's body weight as below: - initial body weight was 210 lb. (pound) on 5/03/24 via wheelchair, - On 5/14/24: 205.2 lb (4.8 lb , 2% loss from the initial weight) via a mechanical lift, - On 5/22/24: 200.8 lb. (9.2 lb, 4.3 % loss from the initial weight) via a mechanical lift, - On 5/28/24: 192.6 lb. (17.4 lb, 8% loss from initial weight) via a mechanical lift. On 2/03/25 at 10:00 AM, a review of Resident #660's progress note revealed that the facility staff documented a nutrition assessment upon the resident's admission on 5/03/24; however, there was no additional documentation regarding his/her nutrition status. During an interview with the clinical nutrition manager (Staff #20) on 2/04/25 at 8:57 AM, she stated that the facility staff addressed residents' body weight changes once a week when they had more than 5% weight differences noted. She added that residents needed to re-weight within 2 days when they had weight changes. And dietitians should address interventions. The surveyor reviewed Resident #660's body weight changes with Staff #20. She insisted that since the resident's weight changes were less than 5% (before 5/28/24), it was not triggered for them. She stated that she was waiting to get the confirmation body weight when it was documented as 192.6 lb, with an 8% loss on 5/28/24. Then, Staff #20 said, The resident was discharged before I got the confirmation body weight. In an interview with the Director of Nursing (DON #1) on 2/04/25 at 10:05 AM, the DON confirmed that she expected nursing staff to re-check residents' body weight, which had a more than 5-pound difference. She verified that the dietitian's trigger went by percentage, but on nurses' scope, they expected to re-check body weight within 24 hours and notify/discuss with providers. The surveyor reviewed Resident #660's body weight and progress note. The DON #1 validated that there was no documentation regarding the resident's nutrition status regarding his/her weight loss trend. During an exit conference on 2/07/25 at 12:30 PM, the surveyor shared the above concerns with the facility Administrator and DONs.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 31145 Based on medical record review and interview, it was determined that the facility failed to maintain complete and accurate medical records in accordance with accepted professional standards. This was evident for 9 (Resident #366, #63, #367, #615, #626, #628, #644, #649, and #650) resident of 108 residents reviewed during the recertification/complaint survey. The findings include: A medical record is the official documentation of a healthcare organization. As such, it must be maintained in a manner that follows applicable regulations, accreditation standards, professional practice standards, and legal standards. All entries to the record should be legible and accurate. 1) On 1/29/25 at 11:49 AM a review was conducted of Resident #366's medical record. Review of the miscellaneous section of the medical record revealed a Hospital Transfer summary for another resident, Resident #367 dated 5/16/24. There were 2 transfer summary entries. There were 22 pages of medical information on the first transfer summary that included Resident #367's name, medical record number, date of birth, patient demographics, medical diagnoses, medications, laboratory results, past medical history, and current medical history. The second transfer summary consisted of 61 pages of medical information that included progress notes from the in hospital stay, summaries, and diagnostic results. On 2/3/25 at 8:11 AM an interview was conducted with the Director of Nursing (DON #1). The DON #1 was shown the electronic medical record where Resident #367's transfer summary was loaded into Resident #366's medical record. The DON asked who uploaded it into the medical record and she confirmed the unit secretary uploaded the transfer summary into the wrong medical record. 34484 2) The facility staff failed to document the administration of narcotic medications on residents' Medication Administration Records for Resident #615, #626, #628, #644, #649 and #650. Review of facility provided documentation on 2/3/25 revealed on 4/29/24 the Director of Nursing #1 (DON) received report from the Assistant Director of Nursing (ADON) of RN #17's medical emergency on 4/10/24 at 2:00 PM and resignation on 4/12/24 via text message. On 4/29/24 the DON began a review of residents' Controlled Medication Utilization Record and medications documented on residents' MARs (Medication Administration Records) for narcotics. a) Review of Resident #615's medical record on 2/3/25 revealed the Resident was admitted to the facility on [DATE] and was assessed by staff to have a BIMS (Brief Interview of Mental Status) of 15 of 15, cognitively intact. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of Resident #615's April 2024 Controlled Medication Utilization Record revealed Staff #17 signed out Oxycodone 5 mg on 4/10/24 at 7:55 AM, 11:57 AM and 3:59 PM. Review of Resident #615's April 2024 MAR revealed the Oxycodone 5 mg on 4/10/24 at 7:55 AM, 11:57 AM and 3:59 PM were not documented as administered to the Resident. Further review of the facility investigation revealed the DON interviewed the Resident on 4/29/24 but the Resident could not recall how many doses he/she received of Oxycodone on 4/10/24. b) Review of Resident #644's medical record on 2/3/25 revealed the Resident was admitted to the facility on [DATE] and was assessed by staff to have a BIMS of 8 of 15, moderate cognitive impairment. Further review of Resident #644's April 2024 Controlled Medication Utilization Record revealed Staff #17 signed out Oxycodone 5 mg on 4/10/24 at 10:55 AM, 2:55 PM and 6:55 PM. Review of Resident #644's April 2024 MAR revealed the Oxycodone 5 mg on 4/10/24 at 10:55 AM, 2:55 PM and 6:55 PM were not documented as administered to the Resident. Further review of the facility investigation revealed the DON interviewed the Resident on 4/29/24 but the Resident could not recall how many doses he/she received of Oxycodone on 4/10/24. c) Review of Resident #650's medical record on 2/3/25 revealed the Resident was admitted to the facility on [DATE] and was assessed by staff to have a BIMS of 15 of 15, cognitively intact. The Resident was then discharged from the facility on 3/9/24. Further review of Resident #650's March 2024 Controlled Medication Utilization Record revealed Staff #17 signed out Tramadol 50 mg on 3/3/24 at 7:55 AM, 3/7/24 at 7:55 AM and 3/8/24 at 7:55 AM and 12:00 PM. Review of Resident #650's March 2024 MAR revealed the Tramadol 50 mg on 3/3/24 at 7:55 AM, 3/7/24 at 7:55 AM and 3/8/24 at 7:55 AM and 12:00 PM were not documented as administered to the Resident. d) Review of Resident #649's medical record on 2/3/25 revealed the Resident was admitted to the facility on [DATE] and was assessed by staff to have a BIMS of 10 of 15, moderate cognitive impairment. The Resident was then discharged from the facility on 4/8/24. Further review of Resident #649's March and April 2024 Controlled Medication Utilization Record revealed Staff #17 signed out Oxycodone 5 mg on 3/21/24 at 8:00 AM, 3/26/24 at 7:55 AM, 3/26/24 at 11:59 AM and 4/4/24 at 8:00 AM. Review of Resident #649's March and April 2024 MAR revealed the Oxycodone 5 mg on 3/21/24 at 8:00 AM, 3/26/24 at 7:55 AM, 3/26/24 at 11:59 AM and 4/4/24 at 8:00 AM were not documented as administered to the Resident. e) Review of Resident #628's medical record on 2/3/25 revealed the Resident was admitted to the facility on [DATE] and was assessed by staff to have a BIMS of 14 of 15, cognitively intact. The Resident was then discharged from the facility on 3/13/24. Further review of Resident #628's March 2024 Controlled Medication Utilization Record revealed Staff #17 signed out Oxycodone 5 mg on 3/2/24 at 12:10 PM, 3/3/24 at 11:57 AM and 3/7/24 at 11:55 AM. Review of Resident #628's March 2024 MAR revealed the Oxycodone 5 mg on 3/2/24 at 12:10 PM, 3/3/24 at 11:57 AM and 3/7/24 at 11:55 AM were not documented as administered to the Resident. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	f) Review of Resident #626's medical record on 2/3/25 revealed the Resident was admitted to the facility on [DATE] and was assessed by staff to have a BIMS of 10 of 15, moderate cognitive impairment. The Resident was then discharged from the facility on 3/14/24. Further review of Resident #626's February and March 2024 Controlled Medication Utilization Record revealed Staff #17 signed out Oxycodone 5 mg on 2/3/24 at 12:40 PM, 2/4/24 1:19 PM, 2/8/24 at 7:55 AM, 12:15 PM, 5:00 PM, 2/9/24 at 1:00 PM, 6:20 PM, 2/14/24 at 11:54 AM, 2/17/24 at 12:00 PM, 2/18/24 at 12:12 PM, 2/22/24 at 7:50 AM, 2/23/24 at 12:07 PM, 2/26/24 at 12:55 PM, 2/27/24 at 1:00 PM, 2/28/24 at 1:12 PM and 3/2/24 at 12:10 PM. Review of Resident #626's February and March 2024 MAR revealed the Oxycodone 5 mg on 2/3/24 at 12:40 PM, 2/4/24 1:19 PM, 2/8/24 at 7:55 AM, 12:15 PM, 5:00 PM, 2/9/24 at 1:00 PM, 6:20 PM, 2/14/24 at 11:54 AM, 2/17/24 at 12:00 PM, 2/18/24 at 12:12 PM, 2/22/24 at 7:50 AM, 2/23/24 at 12:07 PM, 2/26/24 at 12:55 PM, 2/27/24 at 1:00 PM, 2/28/24 at 1:12 PM and 3/2/24 at 12:10 PM were not documented as administered to the Resident. Interview with the Director of Nursing (DON) #1 on 2/4/25 at 12:00 PM confirmed Staff #17 failed to accurately document the administration on narcotic medications for Resident #615, #644, #650, #649, #628 and #626. 47200 3) On 2/3/25 at 12:50PM the surveyor conducted a review of the medical record for Resident #63 which revealed the following two separate medical orders for medications which were incomplete without an indication for use specified: a.) Seroquel Oral Tablet 25 MG, give 0.5 tablet by mouth one time a day, and b.) Amlodipine Besylate Oral Tablet 5 MG, give 1 tablet by mouth one time a day. On 2/4/25 at 9:50AM the surveyor reviewed prior recommendations made by Pharmacist #49 on 9/16/24 and 1/14/25, which included the need for diagnoses and/or indications for use of medications needing to be present within medical orders. On 2/4/25 at 10:14AM the surveyor conducted an interview with Clinical Team Manager (CTM) #50 who confirmed with the surveyor that when creating a medical order for medications, they could utilize either the diagnoses box or the indication for use box in which either would populate the indication for use in the medication order. The surveyor observed the medication orders for Resident #63's Amlodipine and Seroquel with CTM #50 who confirmed with the surveyor that the medication order did not display the indication for use and the diagnosis they had selected for indication of use was not populating to show on the medical order. CTM #50 further confirmed with the surveyor that they enter medication orders in response to pharmacy recommendations after the physician or nurse practitioner has reviewed the recommendations and provided a response. At this time, the surveyor shared their concern that the medical orders did not display an indication for use. CTM #50 acknowledged understanding of the surveyor's concern. On 2/4/25 at 10:39AM the surveyor conducted an interview with the Director of Nursing (DON #1) who confirmed with the surveyor that staff can either select related diagnoses or complete the indication for use box when creating a medical order. The DON #1 reported the following information to the surveyor: I did not know this was not showing under the order, we need to make sure we have the indication for use, most people use the indication section, so we did not know it wasn't showing up on the medical order, I review these and did not see these missing the indications.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34484 Based on review of the facility's pest activity logs and interviews, the facility failed to maintain an effective pest control program. This was evident for 1 of 2 buildings reviewed during the recertification/complaint survey. The findings include: During investigation of multiple complaints including August and October 2024 regarding mice in the facility's [NAME] building from residents' responsible parties the surveyor requested on 2/4/25 the facility's pest control logs from September 2024 through February 4th, 2025. Interview with Staff #23 (Vice President of Building Services) on 2/4/25 at 10:45 AM, Staff #23 states the facility consists of 2 buildings and each building maintains a pest control log at the front desk for the pest control company to address any concerns. Staff #23 stated the pest control company comes to the facility 3 times a week. Review of the Pest Activity Log on 2/4/25 for the [NAME] Building revealed the following entries in patient care areas: 9/2/24 room [ROOM NUMBER] mouse droppings in room, room [ROOM NUMBER] mouse droppings in room 9/4/24 room [ROOM NUMBER]-226 mouse sighting, 4th floor dining room mouse sighting 9/5/24 room [ROOM NUMBER] mice sighting, room [ROOM NUMBER] mice in hallway ran under door to enter room 9/6/24 room [ROOM NUMBER] mice in resident room, so scared might jump on bed 9/11/24 room [ROOM NUMBER] dead mouse in trap 9/12/24 room [ROOM NUMBER] resident reported a mouse jumped on bed yesterday, room [ROOM NUMBER] mice running 9/13/24 room [ROOM NUMBER] patient saw a mouse 9/15/24 5th floor tv room mouse sighting, room [ROOM NUMBER] mice sighting by resident, room [ROOM NUMBER] mouse sighting 9/16/24 5th floor tv room mouse running around, 3rd floor dining room mouse running around, room [ROOM NUMBER] mice sighting, room [ROOM NUMBER] mice sighting 9/17/24 room [ROOM NUMBER] mice sighting 9/20/24 room [ROOM NUMBER] mouse running around bedroom, room [ROOM NUMBER] mice running in and out of closet and around bedroom (continued on next page)

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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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	9/23/24 room [ROOM NUMBER] 2 rats running by room, room [ROOM NUMBER] mouse in room for months, room [ROOM NUMBER] mouse observed in room 9/24/24 room [ROOM NUMBER] mouse running in room 9/25/24 room [ROOM NUMBER] mice running around room 9/27/24 room [ROOM NUMBER] mice in room everynight 9/30/24 room [ROOM NUMBER] mouse seen by resident, 5th floor tv room mice sighted 10/8/24 room [ROOM NUMBER] mice seen in room, room [ROOM NUMBER] mice seen in room, room [ROOM NUMBER] mouse droppings 10/9/24 room [ROOM NUMBER] mice in room, room [ROOM NUMBER] mice in room, 5N/5W hallways mice sightings, 5W tv room mice sightings 10/10/24 room [ROOM NUMBER] live mouse in room, room [ROOM NUMBER] mouse running around room, room [ROOM NUMBER] resident saw mouse in room, room [ROOM NUMBER] mice, 4th floor dining room mouse sighting 10/11/24 room [ROOM NUMBER] last night fat mouse bigger than a mouse smaller than a rat. It was in room running around 10/12/24 room [ROOM NUMBER] live mice running across the room 10/15/24 Rooms 264, 393 and 287 mouse sighted in room 10/17/24 room [ROOM NUMBER] one mouse seen in room, room [ROOM NUMBER] mice in room, room [ROOM NUMBER] mouse running in room, room [ROOM NUMBER] mouse in room 10/18/24 room [ROOM NUMBER] resident reported a mouse in room last night, room [ROOM NUMBER] mouse in room 10/20/24 room [ROOM NUMBER] mouse sighted in room, 4 North tv room mice observed, 4 North nursing station mice observed 10/21/24 room [ROOM NUMBER] mice sighting, 3 North nursing station mice sighting 10/22/24 room [ROOM NUMBER] mouse sighting, mouse sighting 10/23/24 room [ROOM NUMBER] mouse ran from hallway into room, room [ROOM NUMBER] mouse sighting 10/24/24 room [ROOM NUMBER] 3 mice seen, 3 North food prep mice seen by visitor running around, room [ROOM NUMBER]A mouse running (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215071	A. Building B. Wing	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hebrew Home of Greater Washington	6121 Montrose Road Rockville, MD 20852

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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10/25/24 room [ROOM NUMBER] and 279 mouse, 3 North food prep mice running, 4W/3N tv room multiple mice running around, Rooms 370, 368 and 366 mice, 2 N 3 mice spotted crossing hallway, 3 N mouse running in hallway into one of the rooms 10/28/24 Rooms 588, 281, 368 mouse sighted in room 10/29/24 Rooms 391, 389, 266, 387 mouse sighted in room 10/30/24 Rooms 277, 258 mouse sighted in room, room [ROOM NUMBER] mice running around room, keeps running on bed, room [ROOM NUMBER], 464 mice running around room 10/31/24 Rooms 275, 271, 270, 285, 281 mice sighted in room 11/1/24 room [ROOM NUMBER], 410, 556 mouse running around the room, 5W tv room mice, room [ROOM NUMBER] mouse droppings 11/3/24 room [ROOM NUMBER] dead mouse in closet 11/4/24 Rooms 391, 387, 381, 445, 410, 398, 266 mice seen in room 11/5/24 Rooms 554, 560, 566 mouse sighted in room, 5 N tv room mouse seen 11/6/24 Rooms 596, 266 mouse sighted in room 11/7/24 Rooms 445B, 568, 481 mouse sighted in room, Hallway 571-579 mice running 11/8/24 room [ROOM NUMBER] mice running in and out of room, 3N/5W tv area mouse running 11/9/24 room [ROOM NUMBER] mouse in room 11/11/24 4N tv room mice sighted 11/12/24 room [ROOM NUMBER] mice running around room 11/13/24 Rooms 286, 287 mouse sighted in room 11/14/24 room [ROOM NUMBER] family complained continue to see mice in room especially at night, 4N tv room [ROOM NUMBER] mice 11/15/24 4N living area mice 11/18/24 room [ROOM NUMBER] mice sighted in room 11/19/24 Rooms 202, 203, 201 mouse sighted in room 11/22/24 Rooms 558, 283 mouse sighted 11/25/24 Rooms 406, 407 mouse sighed in room (continued on next page)

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	215071	A. Building B. Wing	02/07/2025

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Hebrew Home of Greater Washington	6121 Montrose Road Rockville, MD 20852

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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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	12/3/24 room [ROOM NUMBER] mouse sighted in hallway, room [ROOM NUMBER] droppings in room 12/4/24 3 N tv room mouse sighted 12/6/24 room [ROOM NUMBER] mouse observed 12/9/24 room [ROOM NUMBER] 2 mice moving around room 12/13/24 room [ROOM NUMBER] mice running in and out of bedroom 12/14/24 room [ROOM NUMBER] live mouse seen in room, room [ROOM NUMBER] mouse coming into room 12/15/24 Rooms 516, 526, 394, 395 mouse sighted in room 12/17/24 room [ROOM NUMBER] dead mouse in trap 12/18/24 3 N tv room mice seen, 3 N nurses station mice seen, room [ROOM NUMBER] mice seen 12/19/24 3 N tv room [ROOM NUMBER] mice running across room and nursing station 12/25/24 room [ROOM NUMBER] mouse observed in room 12/26/24 4 N tv room mouse running under A/C 12/27/24 room [ROOM NUMBER] mouse seen, 3 N nursing station mouse seen 12/30/24 Rooms 516, 520, 524 mouse sighted in room 1/2/25 4 W tv room dead mouse on trap 1/5/25 room [ROOM NUMBER] dead mouse in room, room [ROOM NUMBER] dead mice on glue board, 1st floor nursing station dead mouse on snap trap 1/19/25 Rooms 383, 373, 397, 394, 388 mouse sighted in room 1/22/25 Mouse in hallway outside room [ROOM NUMBER] 1/24/25 5 N shower room Resident saw a mouse in the shower room, room [ROOM NUMBER] Resident saw a mouse in hallway by room 1/30/25 room [ROOM NUMBER] Patient reported seeing a mouse in room 2/2/25 room [ROOM NUMBER] mouse caught on glue board 2/3/25 3 N tv room mouse sighted in room, 3 N nurses station mouse sighted, room [ROOM NUMBER] mouse sighted in room The Surveyor then conducted the following interviews on 2/4/25 and 2/7/25: (continued on next page)

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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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the resident in room [ROOM NUMBER] on 2/4/25 at 1:54 PM, the resident stated he/she saw a mouse in his/her room last week. Interview with the resident in room [ROOM NUMBER] on 2/4/25 at 1:55 PM, the resident stated he/she sees a mouse every day that runs from the closet to under the dresser in his/her room. Interview with the resident in room [ROOM NUMBER] on 2/4/25 at 2:04 PM, the resident stated he/she has a mouse under his/her chair every night. Interview on 2/4/25 at 2:05 PM with GNA #45 (geriatric nursing assistant), she stated she saw a mouse last week in the resident hallway and told the housekeeper. Interview with the resident in room [ROOM NUMBER] on 2/4/25 at 2:10 PM, the resident stated he/she saw a mouse about 2 weeks ago and told the staff. Interview with the resident in room [ROOM NUMBER] on 2/7/25 at 8:50 AM, the resident stated saw a mouse a couple days ago in his/her room. Interview with the resident in room [ROOM NUMBER] on 2/7/25 at 8:57 AM, the resident stated he/she saw a mouse last week in his/her room. Interview with the resident in room [ROOM NUMBER] on 2/7/25 at 9:00 AM, the resident stated he/she saw a mouse 2 weeks ago that ran from under the heater. Interview with the resident in room [ROOM NUMBER] on 2/7/25 at 9:03 AM, the resident stated he/she saw a mouse in the hallway last night. Interview with the resident in room [ROOM NUMBER] on 2/7/25 at 9:05 AM, the resident stated he/she sees a mouse in his/her room every night. Interview with the resident in room [ROOM NUMBER] on 2/7/25 at 10:36 AM, he/she saw a mouse in his/her room a couple of days ago. Interview with the resident in room [ROOM NUMBER] on 2/7/25 at 10:39 AM, the resident stated he/she saw a mouse in his/her room last night. Interview with the resident in room [ROOM NUMBER] on 2/7/25 at 10:41 AM, the resident stated he/she saw a mouse a week ago at the doorway to room. Interview with the resident in room [ROOM NUMBER] on 2/7/25 at 10:43 AM, the resident stated he/she saw a mouse run across the hallway through the shower room last week. The findings were reviewed with the Administrator on 2/7/25 at 12:30 PM.