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	10/17/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to keep the resident free from verbal and mental abuse as evidence by a social worker demonstrating verbal and non-verbal aggressive behavior toward the resident which caused and had the potential to cause the resident to experience humiliation, intimidation, shame, agitation, and/or degradation and did not promote an environment to enhance the resident's dignity. An observation of Resident 17 (R17) on 10/17/25 at 9:40 a.m., revealed a well-groomed person lying in bed who had just finished eating lunch independently. R17 was pleasant and engaging with good recollection of the incident. The room was clean, uncluttered and odor free. An interview with R17 on 10/17/25 at 9:40 a.m., revealed he/she recalled the incident with the Social Worker (SW24) in detail. R17 stated SW24, talked a lot and always had a negative connotation or attitude and that was typical of SW24. R17 stated during the incident, SW24 Jumped up and shouted and screamed, which made R17 feel disrespected and degraded. R17 stated that he/she has not worked with SW24 since the incident. An interview on 10/16/25 at 2:15 p.m. with the Director of Nursing (DON), revealed the witness to the incident was a support planner from a community integration services company who was working with R17 regarding placement outside of the facility. The DON stated that the support planner did not report the incident and was later educated by the Director of Social Work regarding professionalism and abuse. Several attempts were made to contact the support planner. A voicemail and email were sent without return correspondence. In an interview with the facility's human resources representative (HR23) on 10/17/25 at 11:30 a.m., he/she stated SW24 was terminated due to a pattern of behavioral infractions, including the incident with R17, adding that SW24 had violated the facility's policies regarding communication style and code of conduct. A review of R17's medical record Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15/15, indicating the resident had intact cognition. Further review of the resident's record revealed no diagnoses of, medications or treatment for dementia, impaired cognition, mood or behavioral disturbances. A review of R17's progress notes between 6/15/25 and 7/16/25 did not reveal any documentation of the incident being investigated.A review of the facility investigation for revealed a thorough and appropriate investigation with timely reporting to the appropriate entities although it did not verify abuse. Instead, the facility verified Quality of Care/Treatment and Administration/Personnel. The facility investigation showed R17 reported the incident to the Clinical Team Manager (CTM) and Supervisor on 6/25/25, telling them that the incident had occurred on 6/20/25 in SW24's office with the community planner present. SW24 was immediately removed from the schedule pending investigation. During the investigation on 7/2/25, R17 stated to the investigator that he/she felt like SW24 was going to come across the desk and hit her. Further review of the investigative conclusion documented, .the behavior of SW24 was inappropriate, unprofessional, and humiliating toward [R17], and SW24 also stood up in front of [R17] in an intimidating way with an inappropriate tone, which was considered emotional abuse.behavior was inappropriate and threatening toward [R17]. A review of the support planner's statement revealed, . [social worker] spoke at a passionate level that could be understood as yelling by [R17] .I (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	do not think he/she yelled at him/her, but I will say that he/she did reprimand him/her for making the statement.[SW] was a little too passionate.I could tell R17 was not happy with the tone. I would describe it as being called into the principles [sic] office and being chastised for your behavior.o The facility's policy titled, Organizational Policy on Resident Abuse for HHGW dated 03/1998 with last revision and approval date of 01/2025 was reviewed without concerns. Within Section I. Policy Statement, it commands, Any associate, contracted provider, or volunteer, observing, knowing of, suspecting, or receiving any allegation of abuse, neglect or exploitation shall immediately report any of the above circumstances to their immediate supervisor, the Clinical Team Manager for the unit (Hebrew Home of Greater [NAME]), their shift supervisor, or Executive Director. Reporting must be immediate, without delay. Further, the policy defines abuse as, the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse. 3. Psychological or verbal abuse: Mistreatment that affects a person's emotional or mental health or wellbeing, including but not limited to: intimidation, threats of punishment or harm, harassment, humiliation, insults, belittlement, or isolation. The use of oral, written or gestured language that disparages or demeans residents or their families, regardless of their age, ability to comprehend, or disability. Examples include, but are not limited to: threats of harm; saying things to frighten a resident.The facility implemented corrective action plans to include: The termination of SW24, education/in-servicing provided to all staff on abuse and communication which was reviewed without concerns, and education provided to outside coordination of care workers on abuse and reporting and accompanying policy requiring the same. The facility provided a copy of email correspondence between the Director of Social Work and the support planner from the community integration service company. The email was dated 7/3/25 and stated, in part, if you are vising any residents in our facility and you see anything that could be misconstrued as hostile, negative, abusive, or unprofessional by our staff toward any resident, we ask that you inform someone of what you saw, no matter how miniscule or flagrant it may be. We at HHGW want to insure [sic] the best overall experience and safety to our residents. The email was acknowledged and signed by the support planner on 7/7/25.The facility verified the allegations of Quality of Care/Treatment and Administration/Personnel; however, this surveyor's investigation will substantiate a past noncompliance finding of the deficient practice of abuse (mental/verbal) as evidenced by a social worker demonstrating verbal and non-verbal aggressive behavior toward the resident which caused and had the potential to cause the resident to experience humiliation, intimidation, shame, agitation, and/or degradation and did not promote an environment to enhance the resident's dignity.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record revies, the facility failed to provide adequate supervision to Resident 20 utilizing an elopement prevention device as evidenced by R20's elopement from the monitored area and the building of residence for approximately 2 hours. An observation of Resident 20 (R20) on 10/14/25 at 1:20 p.m. revealed a well-groomed person sitting on the side of the bed eating lunch. R20 also had water and juice within reach and, he/she did not require assistance with eating. There was no observable WanderGuard in place. The room was clean, cluttered and odor free. An observation of R20's unit 10/14/25 at 1:20 p.m., unit revealed there were cameras pointing toward the exit door and one in the middle, pointing toward the nursing station. The elopement monitoring system testing was observed and appeared to be working properly. An interview with R20 on 10/14/25 at 1:20 p.m. revealed he/she did not have a WanderGuard device in place. When asked about leaving the building, R20 stated, I can't leave the building, however, he/she could not explain the reason he/she could not leave the building. R20 stated he/she had salmon and rice for lunch. R20 stated he/she felt safe. In an interview on 10/16/25 at 2:15 p.m. with the Administrator and the Director of Nursing (DON), they simultaneously recounted the events that took place during R20's elopement event as follows: R20 was able to call and enter the elevator due to a glitch in the WanderGuard monitoring system, allowing the elevator doors to close and any floor to be accessed. At the time, the system was being tested weekly. The alarm sounded at approximately 5:00 p.m., and staff immediately pursued R20, and a building search was initiated by several staff. Staff who followed R20 exited the elevator on the ground/first floor; however, R20 had gone to the lower/basement level to exit the elevator. During the facility investigation, R20 admitted his/her actions were made with purposeful intent in order to leave undetected. The resident exited by a loading dock door and was not discovered by the cook from Revitz house in the black van until approximately 6:40 p.m. The facility was unable to verify when R20 entered the black van. The cook and another Revitz staff member assisted R20 into the black sedan. The second Revitz House staff member initially drove R20 to Ring House and then eventually back to the [NAME] building where R20 was assisted back to unit 2 North. When asked the definition of elopement, DON stated, Elopement is someone leaving unit without following protocol, without signing out. By definition that was elopement. Staff did not know where he was. The administrator agreed, adding it's a gray area. When asked the reason the facility did not verify the self-report, DON stated, because we found that this man did not have the intent to elope, and because staff saw him get on the elevator. R20's sibling had taken the resident's cellular telephone, and it was R20's intent to go to Verizon to obtain another phone. He did know the procedure to leave and did not follow it. When asked the reason for the WanderGuard placement, the DON responded, .he did not show any signs of leaving but it was the sibling who informed the staff that R20 would leave. When asked about the operation of the WanderGuard system, the administrator stated when the alarm sounded, it should have shut down the means of egress. He/she further explained the elevator doors would open, but they should not close, explaining that was the glitch in the system. The administrator stated that the system is currently working properly with each test, adding the doors will open but they will not close when the alarm sounds. There was also no transmitter on the basement door nor on the loading dock door. The administrator stated that the system is now physically tested to ensure proper functioning three (3) times daily, adding they have begun the process to acquire a new system for both buildings so that when an alarm sounds, the buildings will shut down and disallow anyone exiting. During the facility investigation, R20 was able to take the investigator step-by-step, recounting the entire event, stating the intention was to go to the Verizon store. When asked the reason R20 was not placed within a locked dementia unit, the DON stated R20 did not yet require that level of care, adding that resident's often transition from one unit (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to the other as their level of needed care increases. A review of R20's orders revealed no evidence of an order for a WanderGuard or other location monitoring device. A review of R20's medical record revealed no evidence of a consent for a WanderGuard or similar location monitoring device. A review of R20's medical record Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15/15, indicating the resident had intact cognition. Further review revealed no wandering behavior was present and no wander/elopement alarm was not in use. A review of R20's elopement risk assessments was made revealing three assessments completed on 3/21/25, 4/2/25, and 4/15/25. The assessments dated 3/21/25 and 4/2/25 showed scores of 1, indicating a low risk for elopement. The assessment dated [DATE] showed a score of 3, indicating a moderate risk for elopement. A review of R20's record reveals he/she was receiving physical and occupational therapies throughout the month of April 2025 and had a history of recurrent falls at home on and prior to 3/14/25. He/she required partial assistance for transfers and used a cane and/or a wheelchair for locomotion. A review of R20's care plan dated 3/21/25 and revised on 4/17/25 revealed, [R20] may be at risk for and/or experiencing a decline in psychosocial well-being/perceived quality of life due to change in environment, mobility decline/ deficit. 4/17/2025 room changed from 294 2n to rm407 4w. A review of R20's care plan dated 4/2/25 (prior to the elopement date of 4/13/25) and revised on 4/18/25 stating, [R20] has actual/potential for elopement related to a high elopement risk assessment score, to the resident's recent exit from the facility without informing staff. All interventions on this care plan were initiated between 4/14/25 and 4/16/25 except one. The one exception was initiated on 4/2/25, and it read, Wander guard transmitter to monitor for unsafe wandering. Check for functioning three times a week. A review of R20's Treatment Administration Record (TAR) revealed a schedule for the month of April 2025 for, Wander Guard to Rt leg due to risk of elopement. Every evening shift every Wed The nurse or GNA must take the resident to the elevator and attempt to get on to the elevator. If no sound or alert before or after entry into the elevator, please contact the supervisor and the front desk for a new transmitter, with a start date of 4/3/25 at 3:00 p.m. and no discontinuation date. There were check marks (indicating administered) and staff initials on 4/9/25 and 4/16/25. Two boxes, 4/22/25 and 4/30/25 were blank. All remaining boxes for each day of the month of April 2025 contained the letter x, indicating the task was no required. A review of R20's TAR revealed a schedule for the month of April 2025 for, Wander Guard to Rt leg due to risk of elopement. Every shift check strap and transmitter for placement. Assess, document, and follow-up on related skin issues identified, with a start date of 4/4/25 at 6:00 p.m. and no discontinuation date. The boxes dated 4/1/25 for both shifts contained the letter x, indicating the task was no required. The boxes dated 4/21/25 through 4/30/25 were blank. There were check marks (indicating administered) and staff initials for both shifts in the boxes dated 4/3/25 through 4/20/25 with the exception of a blank box for the morning shift on 4/15/25. A review of R20's TAR revealed a schedule for the month of April 2025 for, Wander Guard to Rt leg due to risk of elopement. In the evening every Mon, Fri Nurse to remind the shift supervisor to check the resident's wander guard using the code alert sensor for functioning. Supervisor to report issues identified to the front desk for replacement with a start date of 4/4/25 at 6:00 p.m. and no discontinuation date. The boxes dated 4/4/25, 4/7/25, 4/11/25, 4/14/25, and 4/18/25 contained check marks (indicating administered) and staff initials. The boxes dated 4/21/25, 4/25/25, and 4/28/25 were blank. The remaining boxes contained the letter x, indicating the task was no required. A review of R20's Social Work Behavioral Health assessment dated [DATE] revealed the resident to be his/her own decision-maker, a review of three most recent BIMS scores of 15/15 each, with baseline dementia, alert and oriented x2, and medication for dementia. The referral was made on 4/10/25 and completed on 4/21/25, and the referral was made due to inappropriate sexual behavior. There was no indication of exit-seeking behavior outlined in the assessment. A review of R20's nursing progress noted dated 4/14/25 at 6:30 a.m., noted the resident was received eating in his/her room at the beginning of the shift and thereafter through the shift pt remain stable calm in room watching TV, and there was no (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	attempt to leave the room noted. A review of R20's social work progress notes dated 4/2/25, 4/6/25, 4/10/25, and 4/11/25, revealed, Behavioral/Mood concerns noted include(s): Sadness Wandering, Patient is constantly asking to go home. Social Work note dated 4/9/25, noted, Worsening Behaviors: Since admitted , see [sic] more confused at times, restless, wandering, strange statements. Check labs. Social Work noted dated 4/14/25, noted, .Yesterday however reports pt had left unit and could not be found in building for ~30 mins. Eventually [R20] was brought back to building. R20 recounted of the elopement to the Social Worker, although R20's recollection does not fully match the review of the events. Notably, R20 stated he/she was able to get to the Verizon store before his/her return, but witnesses and facility documentation do not corroborate that R20 ever left facility proper. R20 recounts a woman returned him to the building; however, witnesses and facility documentation indicate it was a man who returned him to the building. Further SW documentation revealed a conversation with R20's sibling who reports a long history of confusion to include, .a tendency to become confused.resident is very smart and can make stories sound true.has had a couple of delusional episodes here, calling sibling and stating that everyone is in the parking lot under their car hoods fixing their cars. also reports, that while resident was at home, resident called.a bad storm had knocked down a tree which knocked out the windows and flooding. Upon investigation by the sibling, these events did not happen, i.e. there was no storm, power outage, or building damage. The sibling stated, .resident, in many instances, can seem cognitively ok, but that [R20] is not.has periods where he/she is lucid and in the same breath can be fully impaired. The care team along with the DON was updated with this information. Additionally, the social worker noted that a room transfer was initiated but later cancelled due to reevaluation of need for a secured unit. A social work progress note made by the Director of Social work dated 4/14/25, revealed a Brief Cognitive Assessment Tool (BCAT) was conducted with a score of 14, suggestive of Dementia or Severe Cognitive Impairment. A review of the facility investigation for revealed a thorough and appropriate investigation with timely reporting to the appropriate entities although it did not paint a clear and concise recapitulation. Upon review of the facility investigation, a concern of potential Immediate Jeopardy arose which was believed to have had the potential to have caused serious injury, harm, impairment, or death to a resident because of an elopement for approximately two (2) hours. A meeting was held with the Maryland Department of Health (MDH) on 10/16/2025 at 2:30 p.m. to discuss the findings of a potential Immediate Jeopardy. The MDH stated they failed to see the harm or potential harm caused by R20's elopement, and they determined this did not meet the requirements of Immediate Jeopardy. The investigation showed R20 got onto the elevator at 5:00 p.m., and was not located by the Revitz House cook staff until approximately 6:40 p.m. When the cook discovered R20 sitting in the driver's seat of the black van, he/she went back into the Revitz building to request help from another staff member. The cook stated R20 told him/her that he/she was cold and needed help. When the alarm sounded, the resident was followed by staff who exited on the first floor and informed/inquired to the front desk receptionist who had not seen the resident. The staff who followed assumed that because the resident did not exit via the front door that, he/she must have been in one of the units therefore all units, dining rooms, and bathrooms were searched withing the [NAME] building. The Missing Person Alert was also not activated for the same reason.The facility's elopement policy titled, Resident Elopment-Hebrew Home of Greater [NAME], dated 09/1998 with last revision and approval date of 5/2025 was reviewed without concerns. It defines elopement as, refers to when a resident leaves the premises or a safe area without authorization (i.e., an order for discharge or leave of absence) and/or any necessary supervision to do so. The facility implemented corrective action plans to include: Revision of the resident elopement policy and procedures, in-servicing staff on Missing Resident Response Protocol & Prevention, an increase WanderGuard testing to three (3) times daily, an updated care plan for R20, and updated treatment administration record to monitor R20's behavior.The facility did not verify the allegation of Quality of Care/Treatment; however, this surveyor's investigation will substantiate a past noncompliance finding of the deficient practice of residents receiving adequate (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	supervision and assistance devices to prevent accidents as evidenced by R20's elopement from the monitored area and the building of residence for approximately 2 hours.