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	04/23/2026

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 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. Based on review of a Facility Reported Incident (FRI), record review, and interviews with staff, it was determined that facility failed to ensure timely notification of death to a resident's family. This was found to be evident for 1FRI (#2685784) out of 15 FRI's reviewed during the annual recertification survey.The findings include:On 4/23/2026 at 8:20AM, a review of FRI #2685784 revealed that the family member of Resident #435, who was enrolled in hospice care, expressed the concern that the resident passed away on 11/9/2025 somewhere around 7PM and the facility failed to notify the family/resident representative on 11/9/2025 until nearly 10PM. A review of Resident Change Evaluation (END OF LIFE) document completed on 11/10/2025 revealed that the resident was noted with no pulse, no respiration, no blood pressure, and no temperature at 7:35PM on 11/9/2025, while the family/resident representative notification was not recorded until 10:00PM that evening.During an interview with Director of Nursing (DON) #2 on 4/23/2026 at 8:45AM, the Surveyor expressed the concern regarding their findings in Resident # 435's Resident Change Evaluation (END OF LIFE) document. DON #2 confirmed the Surveyor's findings. DON #2 informed the Surveyor that following the facility's FRI investigation, it was determined that changes needed to be made with the hospice death notification process and that the facility has agreed to eliminate future delays in notification by ensuring families are called immediately upon confirming a resident's death.

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews with facility staff, it was determined that the facility failed to maintain a safe, clean, comfortable, and homelike environment for residents. This was found to be evident for 2 (Rooms #2111 and #2141) out of 36 resident rooms observed on 2 East [NAME] -Kogod Unit during the annual recertification survey. Additionally, it was determined the facility failed to ensure residents' environment was clean and well maintained. This was found to be evident for 2 (Resident # 278 and Resident # 425) of 31 resident rooms observed during the facility's annual Medicare/Medicaid survey.The findings include: On 4/20/2026 between 9:00AM and 11:00AM, during an initial tour of 2 East [NAME]-Kogod Unit, the Surveyor observed the following environmental concerns: -In room [ROOM NUMBER], structural damage to several boards of the center flooring, including soft spots, gaps between planks, edge chipping, warping, and lifting at the seams.-In room [ROOM NUMBER], a wall vent near the doorway appeared to be held in place by a peeling white duct tape like adhesive.-In room [ROOM NUMBER], there were various pink, cream, and brown colored dry patches of residue that bonded with the fibers in the green colored carpet as well as food particles were found on the carpet near the bedside table. These environmental concerns in rooms [ROOM NUMBERS] were discussed with the Nursing Home Administrator (NHA) and Director of Nursing (DON) #2 on 4/20/2026 at approximately 12:30PM. The NHA and DON #2 acknowledged the Surveyor's concerns to be reviewed with the rest of the administrative team. On 4/23/2026 at 12:35PM, a review of an email from the NHA on 4/20/2026 at 12:23PM confirmed that the facility was moving forward with the repairs for the flooring in room [ROOM NUMBER]. On 4/20/26 at approximately 9:45AM an observation screening was conducted on the 4 [NAME] Unit, and the following concerns were identified: 1. During an interview with Resident # 278 who was in an area near the nurse station, the resident reported seeing a mouse in their room earlier this morning. At this time the surveyor asked the Clinical Team Manager (CTM # 13) to accompany her to the room for a dual observation. Upon entry, the resident's trash can was full and had not been emptied. [NAME] specs were noted on the floor in the corner, and chipping was observed along the wall baseboard area. 2. An observation was made of Resident # 425's room. A large pile of clothes was noted on the floor, extending approximately midway up the wall. The resident stated this is my laundry.'' No appropriate container was in the room to put the clothes in. The Administrator was made aware of all identified concerns at approximately 12:00PM on 0420/2026.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interviews with a resident and staff, it was determined that the facility failed to ensure that a resident's call system was functioning properly. This was found to be evident for 1 resident room (room [ROOM NUMBER]) out of 36 resident rooms observed on 2 East [NAME]-Kogod Unit during the annual recertification survey.The findings include:On 4/20/2026 at 9:30AM, during an initial tour of 2 East [NAME]-Kogod, the Surveyor conducted an interview with Resident #31 in room [ROOM NUMBER]. During the interview, the Surveyor was informed that that call system in his/her room did not work because he/she pressed the call button and no one came to assist them. The resident pressed the call button. The call light above the resident's door failed to illuminate. The call station at the nurses' station failed to activate a call from room [ROOM NUMBER].During an interview with Licensed Practical Nurse (LPN #16), the Surveyor expressed the concerns that Resident #31 stated the call system in their room did not work and that after observing the resident press the call button, the call light failed to illuminate outside the resident's room and the call station at the nurses station did not activate. The Surveyor was informed that when resident presses the call button, the system should trigger a visual light illuminated outside the resident's room and another in the hallway by the nurses' station. An audible alert should be heard, as well as an activation of the resident room number from the call station to alert the staff that a resident needs assistance. Upon testing the system, LPN #16 verified it was not functioning properly and stated that they would notify maintenance immediately.On 4/20/2026 at 10:58AM, the Surveyor heard a beeping noise coming from the call station at the nurses' station on 2 East [NAME]-Kogod. Maintenance staff were observed checking the call system and subsequently informed the Surveyor that Resident #31's call system was now functioning properly.On 4/20/2026 at approximately 12:30PM, the Surveyor informed the Nursing Home Administrator (NHA) and Director of Nursing (DON) #2 of these findings with Resident #31's call system and that maintenance staff addressed the concern and made the necessary repairs.