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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observations and staff interviews, it was determined that the facility failed to ensure that the resident had reasonable accommodation of their needs. This was evident for 1 resident (Resident #2) out of 8 residents reviewed during this survey.The findings include:On 4/20/2026 at 9:53 AM, the surveyor observed Resident #2's call bell hanging on the wall out of reach. The surveyor observed that Resident #2 had restraint mittens on their hands, and the call bell was a push button.The following day, 4/21/2026 at 12:33 PM, Resident #2's call bell was observed hanging on the wall, not within reach of the resident due to immobility. The surveyor asked the unit manager, LPN #8, to come to Resident #2's room with her. LPN #8 was asked where the call bell was. LPN #8 saw the call bell hanging on the wall. LPN #8 stated that the GNA must have left it there after changing them. LPN #8 confirmed that the call bell was hanging on the wall. The surveyor then pointed out that the call bell was a push-button model and asked LPN #8 how Resident #2 was supposed to use it when their hands were wearing restraint mittens. LPN #8 stated she would have it changed to the flat call bell so the resident could use it.

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

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 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.

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and facility staff interviews it was determined that the facility failed to ensure that the local Ombudsman was notified of the facility's resident discharges and transfers in a timely manner, at least monthly. This was found to be evident for 2 (#10, #319) out of 5 residents reviewed for hospitalizations during an annual recertification survey. The findings include: 1. On 4/22/2026 at 9:07AM, during a review of Resident #10's electronic medical record, the Surveyor discovered that the resident was hospitalized on [DATE] due to shortness of breath. On 4/22/2026 at 11:25AM, during an interview conducted with (DON) #2, the Surveyor was informed that the local Ombudsman is notified of resident discharges and transfers on a monthly basis. By the 5th of each month, an email is sent by DON #2 to the local Ombudsman notifying them of the discharges and transfers for the previous month. A review of the Resident Response List, generated on 12/4/2025 at 8:59AM for discharges and transfers for November 2025 and emailed to the Ombudsman 12/4/2025 at 9:04AM, failed to include Resident #10's transfer to the hospital on [DATE]. DON #2 confirmed that Resident #10 was not on the list. 2. On 04/22/2026 at 7:40 AM, the surveyor conducted a record review. During the record review, the surveyor could not locate any documentation indicating that the facility notified the local Ombudsman's office of Resident #319's transfer to the hospital on [DATE]. On 04/22/2026 at 8:03 AM, the surveyor interviewed the Director of Nursing (DON) #2. The surveyor asked the DON #2 if the facility notifies the local ombudsman's office of resident transfers and discharges to the hospital. The DON #2 stated that the facility notifies the local Ombudsman's office monthly, at the beginning of the month, via email of resident transfers and discharges to the hospital. Also, DON #2 indicated that she would provide the surveyor with a copy of the email that was provided to the local Ombudsman's office, which lists Resident #319's transfer to the hospital on [DATE]. On 04/22/2026 at 8:37 AM, the surveyor interviewed the DON #2. The DON #2 mentioned that the list of resident transfers and discharges to the hospital that occurred in December 2025 was emailed to the local Ombudsman's office in January 2026; however, the facility forgot to include Resident #319's transfer to hospital on that list. DON #2 also mentioned that the expectation of the facility is to provide the local Ombudsman's office with a list of all residents that were transferred or discharged to the hospital in a timely manner. On 04/22/2026 at 7:40 AM, the surveyor conducted a record review. During the record review, the surveyor could not locate any documentation indicating that the facility notified the local Ombudsman's office of Resident #319's transfer to the hospital on [DATE]. On 04/22/2026 at 8:03 AM, the surveyor interviewed (DON) #2. The surveyor asked DON # 2 if the facility notifies the local Ombudsman's office of resident transfers and discharges to the hospital. (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	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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	DON # 2 stated that the facility notifies the local Ombudsman's office monthly, at the beginning of the month, via email of resident transfers and discharges to the hospital. DON #2 indicated that she would provide the surveyor with a copy of the email that was provided to the local Ombudsman's office, which lists Resident #319's transfer to the hospital on [DATE]. On 04/22/2026 at 8:37 AM, the surveyor interviewed DON # 2. DON #2 mentioned that the list of resident transfers and discharges to the hospital that occurred in December 2025 was emailed to the local Ombudsman's office in January 2026; however, the facility forgot to include Resident #319's transfer to hospital on that list. DON #2 also mentioned that the expectation of the facility is to provide the local Ombudsman's office with a list of all residents that were transferred or discharged to the hospital.

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 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. Based on observation, interview, and record review, the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice by not following the physician's order for applying a hand mitt restraint. This deficient practice was identified for 1 (#2) of 8 residents reviewed for physician orders.Findings include:On 4/20/2026 at 9:53 AM, the surveyor observed Resident #2 in bed wearing hand mitt restraints on both hands.On 4/21/2026 at 10:35 AM, the surveyor observed Resident #2 wearing only one mitt on the left hand. The surveyor immediately interviewed the Unit Manager, LPN #8, regarding the prior observation. LPN #8 stated that the mitt had been removed from the resident's right hand because the physician's order specified application to the left hand only.On 4/21/2026 at 12:59 PM, the surveyor reviewed the medical record for Resident #2. Review of the physician's orders confirmed the following directive: Apply hand mitt to left hand to prevent removal of G-tube and/or self-injury. Monitor and document every shift for safety, skin integrity, and continued need. Remove at least once per shift for skin assessment and range of motion. Attempt daily trial removal when condition permits.The order further required ongoing evaluation and documentation of the restraint's continued need, including assessment of behavior, safety risk, skin integrity, and alternative interventions weekly.The observation on 4/20/2026 revealed that Resident #2 was wearing mitt restraints on both hands, which contradicted the physician's order specifying use on the left hand only.This failure to follow the physician's order placed the resident at risk for unnecessary restraint use and did not ensure care and treatment in accordance with professional standards of practice.

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 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 and interviews with facility staff it was determined the facility failed to ensure that a resident's environment is kept free of accident hazards. This was found to be evident for 1 (#178) of 31 resident rooms observed on the 4 [NAME] Unit during the facility's annual Medicare/Medicaid survey.Findings include:On 4/20/26 at approximately 10:00AM an observation screening was conducted on the 4 [NAME] Unit. Upon entering Resident # 178's room, a wooden mousetrap was observed on the windowsill. The resident was lying in bed at the time of the observation. At this time the surveyor requested a dual observation to be done with GNA # 14 who was in the hallway at this time. The GNA observed the mousetrap on the windowsill and stated that it should not have been in the windowsill and proceeded to remove it, and it snaped shut. The GNA stated that the mat that was on the floor next to the bed was placed there for safety. She confirmed that the resident ambulates in the room but does have confusion. The GNA stated that she would get maintenance to retrieve the mouse trap.During an interview with the DON # 2 on the same date at approximately 11:32AM she was made aware of the concerns regarding a wooden mousetrap on the resident's windowsill, she stated that it should have been placed where the resident cannot access it. She stated that education would be provided for staff.

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on observation and interview, the facility failed to ensure that residents received care from competent, properly trained nursing staff in accordance with professional standards of practice. This deficient practice was identified for 1 (Resident #140) of 5 residents reviewed for staff competency and had the potential to place residents at risk for aspiration and other adverse outcomes.Findings include:On 4/20/26 at approximately 9:30 AM, during observation rounds, Resident #140 was observed lying in bed at approximately a 15-degree elevation while being fed by a care provider who was seated beside the bed. During the observation, the resident was heard yelling, my stomach hurts.The surveyor asked the care provider whether the resident's head should be elevated during feeding. The care provider stated, no. The resident identified the individual as his/her caregiver, stating that she feeds him/her regularly and provides care. The caregiver confirmed this information.When asked about her credentials, the care provider stated she was not a Geriatric Nursing Assistant (GNA) or Certified Nursing Assistant (CNA). She further stated she provides care for the resident until 12:00 PM, at which time another agency staff member assumes responsibility.As the surveyor exited the room, GNA #10 was asked whether she was assigned to Resident #140. GNA #10 stated, no, s/he has a private duty sitter, and confirmed that the sitter was scheduled to work until 12:00 PM.The Unit Manager (Staff #16) was informed of the observation at that time.During an interview on 4/20/26 at 11:00 AM, the Director of Nursing (DON) (Staff #2) stated that residents should only be assisted with eating by facility-trained staff. The DON further stated that she would investigate the situation.During a follow-up interview on 4/21/26, the DON stated that all Unit Managers had been in-serviced regarding the facility's policy, and that GNAs and CNAs would receive additional in-service training by the Unit Managers. The DON also stated that Resident #140's caregiver had been educated on the facility's policy.

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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview and record review, it was determined that the facility failed to make reasonable effort to substitute alternative meal through observations of meals not being eaten. This was evident for 1 (Resident #193) out of 1 residents reviewed for food/drink during the annual survey.The findings include: An observation regarding Resident #193 that occurred on 04/20/2026. At 1:25 PM, the resident declined their lunch tray, informing Geriatric Nursing Assistant (GNA) #15 that the food was too hard and that they do not eat fish. The resident stated an egg salad sandwich would be nice. Despite this direct request, GNA #15 took no action to contact the kitchen for an alternative meal.At 1:31 PM, this surveyor alerted the Unit Manager #7, who visited the room and heard the resident repeat the request for egg salad sandwich. The Unit Manager noted that GNA #15 omitted a request for the resident, who was hungry. The kitchen was subsequently notified to prepare an alternative tray; later the resident was observed eating and finishing an egg salad sandwich.Conducting a follow-up interview with Resident #193. During our conversation, the resident was able to make needs known and stated they were unaware that alternative trays could be requested. A record review conducted on 04/21/2026 at 08:33 AM for Resident #193 revealed the following information:- Medical History: The resident was admitted in 2022 with a history of stroke, unspecified dementia without behavioral disturbance, and anxiety disorder.- Assessments: The BIMS score from the previous year's quarterly assessment was 12.- Dietary and Nutrition: A diet order dated 11/12/2025 included a daily snack at 2 PM, and nutrition notes indicate the resident was on weight monitoring.- Meal Documentation: The kitchen's lunch meal ticket from 04/20/2026 listed an alternative for egg salad but failed to specify the no fish restriction.BIMS (Brief Interview for Mental Status) It is a mandatory tool used to screen and identify the cognitive condition of residents upon admission into a long-term care facility. BIMS Score: 0-7 points as Severely Impaired Cognition, 8-12 points as Moderately Impaired Cognition and 13-15 points as Intact Cognition.During an interview with Unit Manager #7 on 04/21/2026 at 11:03 AM, we discussed findings regarding practice concerns at the facility staff. Specifically, it was noted that Resident #193 has lived in the facility for over four years but remains unaware of available alternative trays. Additionally, staff have not made any effort to offer these alternatives even with being prompted. Final interview with the Administrator, 4/23/26 at 12:30 PM, reviewing the concern as a deficiency practice. He stated the facility staff will be re-educated.

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on record review and interviews with staff, it was determined that the facility failed to maintain medical records in accordance with accepted professional standards and practices. This was found to be evident for 1 (Resident #10) out of 4 residents reviewed for hospitalizations during the annual recertification survey.The findings include:On 4/22/2026 at 9:07AM, during a review of Resident #10's electronic medical record, the Surveyor discovered that the resident was hospitalized on [DATE] due to shortness of breath. However, further review revealed the Notification of Discharge/Transfer from HHGW was not completed until 12/2/2025.On 4/22/2026 at 11:25AM, a review of the Resident Response List for discharges and transfers from November 2025, which was emailed to the Ombudsman 12/4/2025 at 9:04AM, failed to include Resident #10's transfer to the hospital on [DATE]. DON #2 confirmed that Resident #10 was not on the list. Additionally, a review of the Resident Response List for discharges and transfers from December 2025, which was emailed to the local Ombudsman on 1/6/2026 at 1:20PM, revealed that Resident #10 had an emergency transfer to the hospital on [DATE]. DON #2 confirmed that the resident was on the list. The Surveyor expressed the concern that Resident #10 was incorrectly identified as having an emergency transfer on 12/2/2025 in the December report. DON #2 confirmed these findings and the Surveyor was informed that discharges and transfers for the month are retrieved from the electronic health record's Notification of Discharge/Transfer from HHGW form type search. Nursing staff are expected to complete the Notification of Discharge/Transfer from HHGW form, along with other discharge documentation, on the same day the resident is discharged or transferred from the facility. DON #2 acknowledged that the delay in completing the form resulted in inaccurate reporting to the local Ombudsman and stated that staff education will be provided to address these concerns.

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 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.