STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215022	A. Building B. Wing	04/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
King David Nursing and Rehabilitation Center	4204 Old Milford Mill Road Baltimore, MD 21208

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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 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. Based on record review and interview it was determined that the facility failed to inform and give written notice for the reason for a room change to a Resident's Representative (RP). This occurred on 3 out of 3 bed reassignments made for Resident #23. The findings include: On 4/17/25 at 12:54 PM, the surveyor reviewed Resident #23's room census. The review revealed that on 10/16/23, 10/15/25 and 1/28/25 Resident #23 was relocated to a different bed assignment. On 4/17/25 at 2:32 PM, the surveyor requested from the Nursing Home Administrator (NHA) the written notice with reason for room change for Resident #23. On 4/18/25 at 8:41 AM, the surveyor conducted an interview with the NHA. During the interview the NHA stated that when a resident bed assignment is going to change the resident or the RP is told about the room change. However, confirmed that there was no documentation to validate that Resident #23's RP was notified with the reason on any of the bed reassignments.

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	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on record review and interviews, it was determined that the facility failed to protect a resident from abuse from another resident. This was found evident of 1 (Resident #47) out of 8 Residents reviewed for abuse allegations during an annual and complaint survey. The findings include: On 4/16/25 at 10:35 AM, the surveyor reviewed a complaint. The complainant alleged that Resident #23 was witnessed sexually harassing his/her roommate and nothing was being done about it. On 4/17/25 at 2:13 PM, the surveyor reviewed Resident #23's medical record. The review revealed a progress note written by Licensed Practical Nurse (LPN) #8 on 4/9/24 at 12:44 PM that stated, Resident was observed as touching and exposing his/her private part and was also inviting the roommate to participate on it with him/her. A care plan was initiated on 4/10/24 that stated Resident #23 has a behavior problem related to sexual inappropriateness with a female staff. One of the interventions listed was, intervene as necessary to protect the rights and safety of others. Another was, remove from the situation and take to alternate location as needed. On further review, a progress note written by LPN #8 on 4/11/24 stated, the Resident continued to exhibit this behavior of grabbing his/her private area and showed it to whoever entered his/her room. On 4/18/25 at 6:45 AM, the surveyor reviewed the Resident room census on 4/9/24. The review revealed that Resident #47 was Resident #23's roommate. On 4/18/25 at 9:15 AM, the surveyor interviewed Resident #47. During the interview Resident #47 confirmed he/she roomed with Resident #23. Resident #47 stated that he/she could recall one incident where Resident #23 exposed him/herself explicitly to him/her and felt uncomfortable. Resident #47 stated he/she requested to move rooms shortly after the incident. On 4/21/25 at 7:55 AM, the surveyor conducted an interview with the Nursing Home Administrator (NHA). During the interview the surveyor reviewed the concern of abuse and that the facility failed to protect Resident #47 from Resident #23's sexual inappropriate activities.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on a complaint, medical record review and interviews with a resident and staff, it was determined the facility staff failed to report an allegation of abuse to the regulator agencies and Office of Health Care Quality (OHCQ). This was found evident in 1 (Resident #47) out of 8 residents reviewed for abuse. The findings include: On 4/16/25 at 10:35 AM, the surveyor reviewed a complaint. The complainant alleged that Resident #23 was witnessed sexually harassing his/her roommate and nothing was being done about it. On 4/17/25 at 12:43 PM, the surveyor interviewed the Nursing Home Administrator (NHA). During the interview the NHA confirmed that the facility did not have any investigation in regard to Resident #23. On 4/17/25 at 2:13 PM, the surveyor reviewed Resident #23's medical record. The review revealed a progress note written by Licensed Practical Nurse (LPN) #8 on 4/9/24 at 12:44 PM that stated, the Resident was observed as touching and exposing his/her private part and was also inviting the roommate to participate on it with him/her. On further review a progress note written by LPN #8 on 4/11/24 stated, Resident continued to exhibit behavior and grab his/her private area and show it to whoever entered his/her room. On 4/17/25 at 2:28 PM, the surveyor conducted an interview with the NHA. During the interview the surveyor showed the NHA the progress notes written by LPN #8. The NHA stated he was unaware of this allegation and if it had been brought to his attention he would have reported and investigated the incident. He confirmed that the allegation was not reported even with a staff documenting knowledge of the incident.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of a complaint, review of facility investigations, record review, and interviews it was determined that the facility failed to: 1) prevent potential abuse after a documented incident occurred and 2) failed to complete a thorough investigation and maintain the records of their investigation. This was found evident of 1 (Resident #47) out of 8 residents reviewed for abuse and 1 (Resident #68) out of 9 residents reviewed in facility reported incidents. The findings include: 1a) On 4/16/25 at 10:35 AM, the surveyor reviewed a complaint. The complainant alleged that Resident #23 was witnessed sexually harassing his/her roommate and nothing was being done about it. On 4/17/25 at 2:13 PM, the surveyor reviewed Resident #23's medical record. The review revealed a progress note written by Licensed Practical Nurse (LPN) #8 on 4/9/24 at 12:44 PM that stated, the Resident was observed as touching and exposing his/her private part and was also inviting the roommate to participate on it with him/her. On further review, a progress note written by LPN #8 on 4/9/24 stated, Resident continued to exhibit behavior and grabbed his/her private area and showed it to whomever entered his/her room. On 4/18/25 at 6:45 AM, the surveyor reviewed the Resident room census on 4/9/24. The review revealed that Resident #47 was Resident #23's roommate. On further review is was noted that Resident #47 was in room [ROOM NUMBER]-b from 9/29/23 to 5/4/24. Resident #23 resided in room [ROOM NUMBER]-a from 10/16/23-10/14/24. Neither resident was removed from the room after staff was aware of the behaviors. 2a) On 4/16/25 at 11:45 AM, the surveyor reviewed the investigation file for a facility reported incident regarding Resident #68. The incident alleged that a Geriatric Nursing Assistant (GNA) misappropriated funds from Resident #68's bank account. Nowhere in the file was a statement from Resident #68. The file did not contain any documents or notation to demonstrate that the facility investigated the bank account transactions. On 4/16/25 at 12:32 PM, the surveyor conducted an interview with the Nursing Home Administration (NHA). During the interview the surveyor asked the NHA if during the investigation he obtained a statement from the Resident or reviewed any banking statement to validate the facility thoroughly investigated the allegation. The NHA stated he did take a statement and was not sure why it was not kept in the file. He further stated that he was able to review documents provided by the Resident however, he/she did not want the facility to have them. The surveyor reviewed the concern without notation nor a statement in the investigation. It appeared that it was not thoroughly investigated. The NHA stated he would check on his computer to see if the statement was there. The NHA returned with a one sentence typed statement that stated, Resident #68 thinks the GNA saw bank account folder that was in his/her drawer and used it to access the bank account on Resident #68's phone. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2b) On 4/21/25 at 9:25 AM, the surveyor reviewed the investigation file into an allegation that a nurse was verbally abusive to Resident #68. Nowhere in the investigation was a statement given by Resident #68. On 4/21/25 at 11:23 AM, the surveyor interviewed the NHA. During the interview the surveyor asked if the facility investigated and took a statement from Resident #68 in regards to the allegation. The NHA stated he was not sure why the statement was not in the file but would confirm with the Unit Manager that a statement was taken. No statement was provided to the surveyor

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition Based on record review and staff interview, it was determined that the facility failed to comprehensively assess a resident who has had a significant change in status using the CMS-specified Resident Assessment Instrument (RAI) process and weight change. This was evident for 2 (Resident #101 and #16) out of 55 residents reviewed for change of condition. The findings include: The Resident Assessment Instrument (RAI) helps nursing home staff in gathering definitive information on a resident's strengths and needs, which must be addressed in an individualized care plan. 1a) Review of Resident #101's medical record on 4/11/25 at 8:45 AM revealed that Resident #101 had two significant functional changes: significant weight loss and a decrease in functional feeding ability from independent to dependent. Continued review of Resident #101's medical record on 4/11/25 at 9:30 AM revealed the MDS record showed no significant changes in the resident's functional ability at any time during the resident's stay. MINIMUM DATA SET The MDS is a federally mandated assessment tool used by nursing home staff to gather information on each resident's strength and needs. Information collected drives resident care planning decisions. MDS assessments need to be accurate to ensure each resident receives the care they need. Surveyor interview with the MDS Coordinator on 4/16/25 at 9:00 AM confirmed that the facility failed to update the MDS record during the resident's stay. Surveyor interview with the Administrator on 4/17/25 at 10:00 AM confirmed that the facility MDS team failed to update the MDS record correctly during the resident's stay. 2b) On 4/11/25 at 9:18 AM, Resident #16's weights were reviewed. On 10/11/2024, the resident weighed 135.8 lbs. On 04/02/2025, the resident weighed 109 pounds which is a 19.73 % loss over 6 months. On 4/14/25 at 10:21 AM, a review of Resident #16's progress notes was conducted. A Dietitian progress note dated 10/29/2024 at 10:59 AM, stated that Resident #16 had a new weekly weight on 10/25/24 of 125.4 pounds with a Body Mass Index of 22.2. The Dietician stated that the weight loss was significant and documented that the interdisciplinary team, Medical Director, and Resident Representative was made aware of the significant weight loss. On 4/14/25 at 10:35 AM, a Review of the Minimum Data Set was conducted. Section GG - Functional Abilities 00130. Self-care A. Eating: The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident was reviewed and coded as follows: (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/12/24 this section was coded as 05. Setup or clean-up assistance - Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity. On 1/1/25 this section was coded as 01. Dependent - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity. On 4/16/25 at 11:12 AM, an interview with the Minimum Data Set Coordinator (Staff #4) was conducted. Staff #4 was asked when Resident #16 had a significant weight loss and changes to Activities of Daily Living in between assessments, should there have been a significant change coded in the Minimum Data Set. Staff #4 stated they would take a look into the resident's chart to see why there was not a significant change of status assessment conducted in the Minimum Data Set. On 4/17/25 at 9:34 AM, an interview was conducted with Staff #4. Staff #4 stated that they reviewed the resident's chart thoroughly and had missed documenting the significant change of status assessment.

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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. Based on observations, medical record review and interviews it was determined that the facility failed to 1) ensure that a resident's room was free from hazards and 2) adequately monitor a resident with known behaviors. This was found evident for 1 (Resident #68) out of 3 residents reviewed for accidents and 1 (Resident #23) out of 3 Residents reviewed for behaviors. The findings include: 1) On 4/10/25 at 9:36 AM, the surveyor observed Resident #68 ' s bed plugged into an outlet on the other side of the room. On further observation a power-strip was plugged into the second plug and was resting on the floor. An extension cord was then plugged into the power strip. Next the surveyor interviewed Resident #68. During the interview the Resident #68 stated that approximately 4 months ago the outlet on his/her side of the room blew and that he/she had not been able to use the outlet since. Resident #68 stated that currently his/her roommate was in the hospital so he/she could use the outlet, however he/she needed the extension cord to plug charging cords into. On 4/11/25 at 12:31 PM, the surveyor observed Resident #68 ' s room with the Nursing Home Administrator (NHA) and the Director of Maintenance. During the observation the surveyor asked when the roommate returns from the hospital can the bed be plugged into the power-strip. The surveyor also asked if the power strip should be on the floor and an extension cord be plugged into the power-strip. The Maintenance Director stated that the power-strip had been secured to the wall at one point but must have fallen off. He further stated he would look into the power-strip to bed power situation and would look for the bed manual for the surveyor. On 4/15/25 at 7:38 AM, the surveyor conducted an interview with the NHA. During the interview the NHA stated that a new outlet was established for Resident #68 and now Resident #68 had access for his/her bed to be plugged in as well as charging needs without the powers-strip and extension cord use. 2) On 4/17/25 at 2:13 PM, the surveyor reviewed the Resident #23 medical record. The review revealed a care plan that was initiated on 4/10/24 that stated Resident #23 has a behavior problem related to sexual inappropriateness with a female staff. One of the interventions listed was to monitor behavior episodes and attempt to determine underlying cause. Also to consider location, time of day, persons involved, and situations and to document behavior and potential causes. Next the surveyor reviewed Resident #23 ' s psychiatric evaluation dated 2/18/25. The note stated, patient was seen per facility ' s request with noted inappropriate sex behavior. The Resident exhibited his/her private area to others. The note documented that Resident #23 knows what he/she did but he/she was not able to explain why. An additional psychiatric evaluation dated 2/24/25 stated, Resident #23 was seen per facility ' s request due to increasing inappropriate sexual behavior. Per staff he/she is trying to expose self to other people his/her private area. In the plan section it stated, Can not exclude hypersexual personality disorder but needs more monitoring. (continued on next page)

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	215022	A. Building B. Wing	04/21/2025

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The surveyor reviewed the February Treatment Administration Record for February 2025. The TAR had an area to monitor for elopement behaviors. A check mark was checked all three shifts everyday for the month of February. No indication that sexual behaviors were happening even though the psychiatric evaluations stated the facility reported incidences of inappropriate sexual behaviors were happening. The surveyor reviewed progress notes and change of condition evaluations. There was no documentation of these behaviors in the record until a change of condition was written on 2/28/25. The notes stated, Resident has had hypersexualized behavior (touching and exposing him/herself to both staff and other residents on an almost constant basis despite staff redirecting him/her). On 4/18/25 at 1:10 PM, the surveyor interviewed the Nurse Practitioner (NP) working with Psychiatry NP #10. During the interview the surveyor reviewed the 2/24/25 evaluation. The surveyor asked what needs more monitoring meant. Staff #10 stated she was monitoring lab values for the potential start of medications and potentially undiagnosed disorders due to a lack of past medical history. The surveyor reviewed the collaboration section where it stated, discussed patient ' s behavior with staff and recommended to document patient ' s behavior. Staff #10 stated she would expect that Resident #23 ' s behaviors be documented for review. She further stated that she looks for documentation in the progress note section. On 4/18/25 at 1:10 PM, the surveyor reviewed the March 5th 2025 TAR documentation with the Director of Nursing (DON). During the interview the surveyor reviewed the concern that the TAR had yes to behaviors but there was no documentation to what the behavior was. The surveyor reviewed the concern that the behaviors of Resident #23 We are inconsistently or not being documented.

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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. Based on medical record review and interview, the facility failed to accurately document medical information in a resident's medical record and in accordance with acceptable professional standards and practices by keeping complete documentation. This was evident for 2 (Resident #104 and #23) out of 57 residents reviewed during a facility's complaint survey. The findings include: 1a) Surveyor review of Resident #104's medical record on 4/15/25 at 11:00 AM revealed the facility nursing staff failed to document Activities of Daily Living (ADL) care for the resident on 11/10/24 after 7:00 AM. The documentation stated that the resident was not available for nursing staff to provide adl care. Continued review of the resident's medical record on 4/15/25 at 11:30am revealed that the resident was in the facility all day on 11/10/24. Surveyor interview of the administrator on 4/17/25 at 8:30 AM confirmed that the resident was in the facility on 11/10/24 and the Administrator was also unable to explain why the nursing staff failed to document adl care after 7:00 AM on 11/10/24. 2a) On 4/18/25 the surveyor requested the social history assessment completed for Resident #23 from the Nursing Home Administrator (NHA). On 4/18/25 at 7:08 AM, the NHA stated he could not find the social history assessment but would follow-up with the social worker who is responsible for completing the assessment. On 4/18/25 at 8:47 AM, the surveyor conducted an interview with Social Worker #11. During the interview Staff #11 stated she completed the assessment and did not understand why it was not in the medical record.