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	09/18/2025

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on record review and interview it was determined the facility staff failed to make prompt efforts to resolve grievances and keep the resident/representative appropriately apprised of progress toward resolution. This was evident for 1 (#8) of 6 residents reviewed for neglect.The findings include:A complaint involving Resident #8, and Resident #8's medical record were reviewed on 9/15/25 at 11:44 AM.Resident #8 was evaluated by 2 physicians on 3/31/25 and certified to lack mental capacity to make informed medical decisions. The residents' children became his/her surrogate decision makers.The complaint indicated that on the evening of 6/4/25, one of Resident #8's children was concerned that the Residents' condition was deteriorating. They asked Staff #12 a Licensed Practical Nurse (LPN) to call an ambulance. They reported that Staff #12 refused, told them to make the call themselves, argued with the family and failed to check on the resident following their request. The complaint also indicated that an email was sent to the facility's management team and Social Worker that night and no one responded.Review of the facility's Grievance Logs at that same time revealed there were no grievances related to Resident #8 from 4/27/25 to present.In an interview on 9/16/25 at 10:35 AM the Administrator indicated there were no grievances related to Resident #8. He was made aware that the surveyor had reason to believe concerns regarding neglect were sent via email soon after Resident #8 was transferred to the hospital on 6/4/25. He indicated he would check. On 9/17/25 at 10:10 AM the Administrator was asked again and indicated he checked his email and found nothing.When asked if he received any email communication regarding concerns from the Social Worker related to Resident #8, he looked again and stated, an email was sent to Rehab and the Social Worker who forwarded it to me. When asked what was done when he received it, he indicated he wasn't sure, he'd have to look.A copy of the email was provided to the surveyor upon request. Review of the email revealed it was sent by Resident #8's family member on 6/5/25 at 4:18 AM to the Director of Rehab as well as Staff #6, the Social Work Director. Staff #6 forwarded the email to the Administrator on 6/5/25 at 12:12 PM.The email indicated the family member wanted to make a formal complaint regarding the situation that occurred on 6/4/25. It detailed their concerns regarding the events on 6/4/25 and Staff #12's lack of concern, that he became verbally aggressive, loud, disrespectful and unprofessional. Another interview was conducted with the Administrator on 9/18/25 at 8:07 AM, the Director of Nursing was also present. The Administrator confirmed he did not initiate the grievance process and did not follow up with Resident #8's representative. When asked why, he indicated, because Resident #8 was discharged .He confirmed that he is the Grievance Officer for the facility,Cross reference F 609.

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

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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 record review and interview it was determined the facility staff failed to report an allegation of neglect to the State Survey Agency. This was evident for 1 (#8) of 6 residents reviewed for neglect.The findings include:Resident #8's medical record and a complaint involving Resident #8, were reviewed on 9/15/25 at 11:44 AM.The complaint indicated that on the evening of 6/4/25, Resident #8's family members were concerned that the Residents' condition was deteriorating. They asked Staff #12 a Licensed Practical Nurse (LPN) to call an ambulance. The complaint indicated that Staff #12 refused, told them to call 911 themselves, argued with the family and failed to check on the resident following the request to call 911. The complainant also indicated s/he sent an email to the facility's management team and Social Worker later the same night. Review of the email revealed it was sent by Resident #8's family member on 6/5/25 at 4:18 AM to the Director of Rehab as well as Staff #6, the Social Work Director. Staff #6 forwarded the email to the Administrator on 6/5/25 at 12:12 PM.The email indicated that the family member wanted to make a formal complaint regarding the situation that occurred on 6/4/25. It detailed Staff #12's refusal to call 911, and lack of concern including but not limited to: He never came to [Resident #8's] room after I voiced my concerns or after I called for an ambulance and included that Staff #12 became very aggressive and loud when the family member questioned his lack of concern. The email included [Resident #8] is a patient at your facility and should be treated as if they were caring for their own [family], not ignored and left to die.The Administrator and Director of Nursing (DON) were interviewed on 9/18/25 at 8:07 AM. When asked why the nurse didn't call 911 per the family request. The DON stated the nurse did call 911.They confirmed that the allegation was not reported to the State Survey Agency. When asked why, the DON stated, We took it as a customer service issue but immediately saw that it had been addressed by the nurse.Further review of the medical record on 9/18/25 at 9:40 AM revealed a Change in Condition note written by Staff #12 on 6/4/25 at 22:03 (10:03 PM) which included documentation that the resident's family member called 911.The Administrator and DON were made aware that the facility failed to immediately report an allegation of neglect as required then conduct a thorough investigation.Cross Reference F 585.

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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. Based on medical record review and interview with resident and facility staff, it was determined that the facility failed to put interventions in place to prevent the future occurrence of abuse and neglect allegations. This was evident during the review of 2 of 2 allegations of abuse reported by Resident #2.The findings include:1. Medical record review of Resident # 2 on 9/16/25 at 10:30 AM revealed allegations of abuse that occurred during the rendering of activities of daily living (ADL) that was being provided to Resident #2 on 8/23/25 and then again on 9/7/25. Resident #2 first made allegations that his/her rights were violated on 8/23/25 when s/he reported that staff changed and dressed him/her without permission. Resident #2 even stated that s/he had told the staff 'No', but they continued to change his/her shirt anyway. Resident #2 alleged that s/he was held down by the wrists and made to change his/her shirt.Resident #2 was interviewed on 9/16/25 at 12:15 PM regarding what occurred on the night of 8/23/25. S/he stated that his/her regular GNA was not scheduled, and another one came in to provide care during the night shift. Resident #2 stated that s/he agreed to have their bottom changed but said 'no' to changing of the shirt. At that, according to the resident, the GNA left and the room and returned with another GNA to assist in changing the shirt. Resident #2 verbalized to this surveyor that s/he felt assaulted, was yelling and had stated 'no.'2. On 9/7/25 another incident similar in nature occurred with staff GNA #7 during the day shift. Resident #2 alleged that GNA #7 changed [his/her] shirt without permission. GNA #7 was interviewed on 9/17/25 at 1:15 PM regarding her interactions with Resident #2 on 9/7/25. She stated that she had gone in to provide care for him/her with an orientee and they were all ok and initially Resident #2 agreed to get cleaned up and change. However, when we went to change the shirt, the resident became combative. She went on to state that maybe s/he is very specific with the way s/he wants things done. She did state further that they continued to change the resident's shirt. She went on to state that she was removed from patient care while there was an investigation into this new abuse allegation.Resident #2 was interviewed about the incident on 9/7/25 on 9/16/25 at 12:15 PM. S/he was verbally and physically upset as s/he 'stated I just reported this incident on 8/23/25 and then it happened again 2 weeks later, don't I have rights? Don't they have to ask me permission?'The concern that this resident had not one, but 2 similar allegations of abuse occur in a 2-week period with no identifying prevention was reviewed.The DON stated on 9/18/25 at 8:30 AM that notes were put in Resident #2's care plans regarding these events, however, there were no adjustments to the actual plan of care for Resident # 2 that would assist this resident and care givers in potentially working cohesively and preventing future occurrences and allegations of abuse.

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview with staff it was determined that upon resident admission to the facility the physician failed to address a hospital discharge plan to provide CPAP (Continuous Positive Airway Pressure) at night and to wean a resident off supplemental oxygen. This was evident for 1 (#8) of 8 residents reviewed for Quality of Care.The findings include:Resident #8's medical record was reviewed on 9/15/25 at 11:44 AM. The resident was admitted to the facility from the hospital on 3/28/25. Their diagnoses included but were not limited to Obstructive Sleep Apnea and acute respiratory failure with hypercapnia (excessive carbon dioxide in the blood).The hospital Discharge summary dated [DATE] reflected post discharge plans which included but were not limited to: continue to wean off O2 (oxygen) continue with supplemental O2 in the meanwhile Continue with CPAP at night.A CPAP (Continuous Positive Airway Pressure) machine delivers a steady stream of air through a mask to keep the users airway open during sleep and prevent pauses in breathing. The physicians' orders upon admission to the facility included Oxygen inhalation (via nasal cannula @ 2 lpm [liters per minute]).Upon Resident #8's admission, the physician failed to write an order to wean the resident off the supplemental oxygen, and for the use of CPAP at night as indicated in the hospital discharge plan. The Attending Physician, Staff #14's, Medical Visit documentation dated 3/31/25, Section H. Summary of Findings stated, Continue with O2 by nasal cannula Monitor respiratory status History of obstructive sleep apnea Continue with CPAP. However, there was no order at that time for CPAP.The note did not address the plan to wean Resident #8 off supplemental oxygen or rationale for not ordering it.On 4/9/25 an order was written for: Wean off O2. It did not indicate Resident #8's target blood oxygen saturation level.In another physician note on 4/15/25 Staff #14 noted, History of obstructive sleep apnea Respiratory status seems to be at baseline, No dyspnea (shortness of breath) on examination continue with CPAP.However, no orders were written for CPAP. There was no mention of the residents' oxygen weaning and tolerance.On 5/1/25, approximately 1 month after admission, orders were written by the physician for: C-Pap on at night for OSA (Obstructive Sleep Apnea).An interview on 9/16/25 at 10:40 AM the DON (Director of Nursing) was asked how hospital discharge plans were reconciled when residents were admitted to the facility. She explained that the physician will reconcile the orders at the time of admission if in the facility. If they are not in the building the nurse will call the physician and review with the physician via telephone. She was made aware of the hospital plan for Resident #8 and was asked why Resident #8's admission orders and assessment did not include use of CPAP at night and oxygen weaning or rationale for not ordering as per the hospital discharge plan. She indicated she was not sure and would have to check the record and get back to the surveyor. No further information was provided to the surveyor regarding this concern prior to the survey exit. The Administrator was made aware of the above concerns on 9/17/25 at 1:08 PM.Cross reference F 695.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview it was determined the facility failed to develop and implement a comprehensive person-centered plan to meet the residents' needs. This was evident for 1 (#8) of 8 residents reviewed for Quality of Care.The findings include: Oxygen weaning involves the gradual reduction of supplemental oxygen to determine a patient's ability to maintain adequate oxygen saturation on room air. A common approach includes decreasing oxygen flow rates in small increments, observing for symptoms and SpO2 (blood oxygen saturation level) at rest and during activity and ensuring the patient can sustain the target SpO2.A CPAP (Continuous Positive Airway Pressure) machine is a common treatment for sleep apnea, delivering a steady stream of air through a mask to keep the patients airway open during sleep and prevent pauses in breathing.Resident #8's medical record was reviewed on 9/15/25 at 11:44 AM. The resident was admitted to the facility from the hospital on 3/28/25. Their diagnoses included but were not limited to Obstructive Sleep Apnea (OSA) and acute respiratory failure with hypercapnia (excessive carbon dioxide in the blood).A hospital Discharge summary dated [DATE] identified post discharge plans which included but were not limited to: continue to wean off O2 (oxygen) continue with supplemental O2 in the meanwhile continue with CPAP at night.A comprehensive plan of care was developed for Resident #8 on 3/31/25. However, the plan for altered respiratory status/Difficulty Breathing r/t COPD (chronic occlusive pulmonary disease), cough was not added until 4/18/25. The resident's goal was will have no complications related to SOB (shortness of breath). The plan did not identify the residents individualized care needs related to his/her use of supplemental oxygen and diagnosis of OSA.On 4/9/25 the physician ordered oxygen weaning. The Plan of Care was not updated to include a weaning plan, protocol, or the staff responsible.On 5/2/25 an intervention was added for: CPAP SETTINGS: The resident's BiPAP using home machine with settings embedded via (nose mask).The plan of care did not include individualized resident centered interventions for the provision of care related to the resident's use of the CPAP machine such as type of mask, humidification, schedules for replacing/cleaning the tubing, mask, filters, and machine support, provision of supplies and the staff responsible.The Administrator was asked to provide a copy of the facility policies, procedures and protocols related to CPAP, BIPAP and Oxygen Weaning.Review of the facility policies on 9/16/25 at approximately 8:00 AM revealed the policy for Oxygen Administration included, the resident's care plan should identify the interventions for oxygen therapy based on the resident assessment and orders. The policy did not identify the facility's protocol for oxygen weaning. An interview was conducted with the DON (Director of Nursing) on 9/16/25 at 10:40 AM. She was made aware of the above concerns and indicated that the Rehab department is responsible for weaning residents off oxygen. She was unable to explain why Resident #8's plan of care did not include oxygen therapy, an oxygen weaning plan and specific care needs related to CPAP. She indicated that she would have to check and would get back to the surveyor.The DON failed to provide any further information regarding these concerns prior to the end of the survey.The Administrator was made aware of the above concerns on 9/17/25 at 1:08 PM.Cross reference F 695.

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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. Based on medical record review and interview with resident and facility staff, it was determined that the facility failed to revise a care plan related to a resident's specific identified and individualized needs. This was evident during the review of 1 of 3 (Resident #2) resident care plans reviewed for facility self-reports.The findings include:Medical record review of Resident # 2 on 9/16/25 at 10:30 AM revealed multiple comorbidities including concerns with chronic pain, mood and adjustment disorder, cancer and a history of respiratory failure. Resident #2 also recently had 2 allegations of abuse reported to the facility regarding treatment during ADL care.A review of Resident #2's care plans on 9/16/25 revealed care plans initiated on admission in 2024 for said medical diagnosis' including shortness of breath with interventions for example to include proper positioning.However, the care plans related to Resident #'2's mental health, mood disorder and depression, initiated 2/5/24 and 10/29/24 respectively state to administer medications, see a psychiatrist/behavioral health and monitor mood per protocol. There were no interventions individualized to Resident #2. There are also 2 care plans regarding noncompliance with; medications, treatments, ADL care, refuse collection of urine, additionally, resistive to care related to adjustment to nursing home as evidenced by refusal of medication. The goal is [resident] will cooperate with care through next review date. However, the interventions were not individualized for staff to apply towards the residents to improve that resident's life and care. Resident #2 also has a care plan related to behavior of making accusing and confabulatory statements about staff/visual hallucinations,' though what those statements and hallucinations were to look out for were not listed.Again, for this care plan staff were to administer medications, provide psychiatric services as warranted, document the behaviors and discuss with the residents why it was inappropriate or unacceptable, no other interventions were listed from 2024, no individualized prevention.The 3 care plans regarding behaviors from 2024, did not include relevant individualized interventions for Resident #2. It had been established throughout the medical record that Resident #2 had refusals and did not take medications regularly, so having an intervention to administer medications as ordered was not appropriate.These identified concerns were reviewed with the DON and the NHA on 9/18/25 at 8:30 AM. The DON stated repeatedly that she updates the care plans. The surveyors asked for the documentation and proof, and a statement was provided. The statement was a care plan progress notes and evaluation not an actual update to the care plan, that was readily available and visible for all to see.During this interview with the DON on 9/18/25 at 8:30 AM, she also stated that there were no interventions that you could put in place for this resident. However, the concern that this resident had varying needs and concerns related to activities of daily living and there was no corresponding care plan that addressed these needs and concerns was addressed at this time.Again, the DON stated that this cannot be care planned. She was asked what the expectation was then for staff to provide patient centered care if staff are not aware what that patient centered care is; she stated that it always changes with this resident. The concern that there was no individual care plan identified related to this resident verbalized preferences was reviewed at this time i.e. verbalizing staff approval to access dresser drawers, staff getting permission to change resident and reapproaching later when the answer is ‘no.'

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview it was determined the facility staff failed to ensure hospital discharge treatment plans for supplemental oxygen weaning and CPAP use were implemented upon the residents' admission to the facility and failed to have an effective process to wean residents off supplemental oxygen. This was evident for 1(#8) of 8 residents reviewed for Quality of Care.The findings include:Resident #8's medical record was reviewed on 9/15/25 at 11:44 AM. The resident was admitted to the facility from the hospital on 3/28/25. Their diagnoses included but were not limited to Obstructive Sleep Apnea and acute respiratory failure with hypercapnia (excessive carbon dioxide in the blood). The hospital Discharge summary dated [DATE] included post discharge plans which included but were not limited to: continue to wean off O2 (oxygen) continue with supplemental O2 in the meanwhile continue with CPAP at night. Oxygen weaning involves the gradual reduction of supplemental oxygen to determine a patient's ability to maintain adequate oxygen saturation on room air. A common approach includes decreasing oxygen flow rates in small increments, observing for symptoms and SpO2 (blood oxygen saturation level) at rest and during activity and ensuring the patient can sustain the target SpO2.A CPAP (Continuous Positive Airway Pressure) machine is a common treatment for sleep apnea, delivering a steady stream of air through a mask to keep the patients airway open during sleep and prevent pauses in breathing.Resident #8's physicians orders upon admission to the facility included Oxygen inhalation (via nasal cannula @ 2 lpm [liters per minute]).No orders were written to wean the resident off oxygen or for the use of CPAP at night as indicated in the hospital discharge plan.A care plan is a guide that addresses the unique needs of each resident. It is used to plan, assess and evaluate the effectiveness of the resident's care.A baseline plan of care dated 3/28/25 section 3A. Health Conditions/Special Treatments included: 1a. Oxygen therapy = 2 liters/min. It did not include a plan for oxygen weaning. Section 1e. Non-Invasive Mechanical Ventilator (BiPAP/CPAP) was not indicated. The Attending Physician, Staff #14's, Medical Visit documentation dated 3/31/25, Section H. Summary of Findings stated, Continue with O2 by nasal cannula Monitor respiratory status History of obstructive sleep apnea Continue with CPAP. It did not address oxygen weaning.An order was written 4/9/25 for - Wean off O2, it did not identify a target SpO2 level.On 4/15/25 the attending physician noted, History of obstructive sleep apnea Respiratory status seems to be at baseline, No dyspnea (shortness of breath) on examination continue with CPAP. The note did not address supplemental oxygen weaning. On 5/1/25, approximately 1 month after admission, orders were written by the physician for: C-Pap on at night for OSA (Obstructive Sleep Apnea).The order for Oxygen 2L NC (liters, nasal cannula) every shift and oxygen weaning continued. These orders were signed off on the TAR (Treatment Administration Record) as completed by the nurses as ordered.However, there was no indication if and how staff were weaning Resident #8 off the supplemental oxygen such as - an oxygen weaning plan/protocol, the resident's target SpO2 level, and the resident's tolerance/response to the attempts.Cross reference F 635.A plan for altered respiratory status was added to Resident #8's comprehensive Plan of Care on 4/18/25. The plan did not identify the residents' oxygen therapy or oxygen weaning plans, goals, protocol, and responsible staff.The CPAP machine was added to Resident #8's Plan of Care on 5/2/25.Cross reference F 656.The facility policy for Oxygen Administration did not identify a protocol for oxygen weaning including responsible staff/department. An interview was conducted with the DON (Director of Nursing) on 9/16/25 at 10:40 AM. She was asked how the facility reconciles the hospital discharge physicians' orders/recommendations when a resident is admitted from the hospital. She explained that if the physician is in the facility, they will reconcile the orders at the time of admission. If they are not in the building, the nurse will call the physician and review with the physician via telephone. She was made aware and asked why Resident #8's admission orders did not include use of CPAP at night and oxygen weaning as per the hospital discharge plan. She indicated she was not sure and would have to check the record and get back to the surveyor. She was also asked where staff would document oxygen weaning including the resident's response to weaning attempts. She indicated that the Rehab department does oxygen weaning. She confirmed that Rehab staff are only in the facility during the day Monday - Friday, did not work evenings or nights and were not in the facility on weekends.She was asked why nursing staff were signing off oxygen weaning every shift, if they were not involved in the weaning process and where Resident #8's oxygen weaning progress was documented. She indicated that she would have to check and would get back to the surveyor.The DON failed to get back to the surveyor or provide any

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. Based on observation and interview it was determined the facility failed to ensure bed rails were securely affixed to the bed frame to limit entrapment zones. This was evident for 1 (#1) of 1 resident reviewed for Physical Environment.The findings include:An observation of Resident #1's room was made on 9/12/25 at 9:00 AM. 1/4 bed rails were located on both sides of the bed near the head of the bed. The rails were not firmly affixed to the frame, were loose and easily tilted away from the mattress creating a gap approximately 4-5 inches wide between the mattress and the rail. The bed was observed again on 9/15/25 at 9:33 AM, the rails remained loose.On 9/15/25 at 11:15 AM the Administrator was asked to provide the facility's bed rail inspection logs for the past 6 months. He indicated that an inspection was in progress and was asked to provide documentation of the current inspection as well.At approximately 12:00 PM the Administrator provided 1 bed rail audit dated 9/26/24 and indicated that the facility completed bed rail safety audits yearly. He did not provide evidence of the current inspection.On 9/16/25 at 8:00 AM the Administrator was again asked to provide a copy of the current bed rail safety audit. He indicated that it was going to be done the previous day however it was not done.On 9/16/25 at 11:58 AM Staff #11 the Maintenance Director observed Resident #1's bed rails with the surveyor and confirmed they were loose. He indicated he tightened the rails the previous week. However, the loose bed rails were not addressed from 9/12/25 when first observed by the surveyor, until 9/16/25 upon surveyor intervention.The Administrator was made aware of these findings on 9/17/25 at 1:11 PM.