| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215022 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 02/26/2026 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER King David Nursing and Rehabilitation Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 4204 Old Milford Mill Road Baltimore, MD 21208 | |

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) |
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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>Based on the review of an investigation and interviews it was determined that the facility staff failed to ensure a resident was free from verbal abuse This deficient practice was evidenced in 1 (#1) of 3 investigations reviewed for an allegation of abuse during the complaint survey.The findings include:On 02/18/26 at 11:44 am a review of the facility's self-report investigation concerning an allegation of verbal abuse towards Resident #1 revealed the alleged incident occurred on 10/02/25 during the 3:00 pm - 11:00 pm shift. On 10/05/25 during 7:00 am - 7:00 pm Resident #1 reported to Licensed Practical Nurse (LPN) Unit Manager #5 that Geriatric Nursing Assistant (GNA) #13 told them to shut up. The incident was reported at the end of the shift. GNA #13 was working during the time the incident was reported but was assigned to a different unit where Resident #1 was located. The alleged perpetrator was allowed to complete the shift.A disciplinary notice was completed on 10/05/25, the explanation of the infraction was incorrect. The form indicated GNA #13 was suspended and worked the following day on 10/06/25 7:11 am - 11:16 pm. According to the facility's follow-up investigation report GNA #13 and Resident #1 agreed that the statement made was not intended to be rude or harmful. Both acknowledged that the phrase shut up was not directed from GNA #13 to resident #1. A One-on-One Inservice was completed with GNA #13 on 10/05/25. The topic of the in-service was recorded as Resident Rights, Dignity, and Respect. The description of information covered during the in-service was documented as GNA #13 will be able to recognize the difference in culture, religion, age, gender, disability etc. GNA #13 will be able to communicate effectively with residents.On 02/18/26 at 12:30 pm a review of Resident #1 electronic health record revealed the resident's BIMS Score was 15/15 assessment review date (ARD) 09/30/25. A review of the residents' statement was dated 10/05/25 was taken by Administrator #1. The statement read, a GNA told me to shut up, but she apologized after. I don't think she meant it like that. I was just surprised at first.On 02/19/26 at 1:49 pm reviewing a review of GNA #13 employee record; she was hired on 05/30/25, her GNA certificate is active. A background check was completed on 05/30/25 with no reportable records found. Abuse & Dementia training was completed on 05/30/25. On 02/19/26 at 2:02 pm during an interview with GNA #13 the surveyor asked her to review her statement from the investigation. After reviewing the statement GNA #13 confirmed the statement was accurate and confirmed she told the resident to calm down and shut up. GNA #13 confirmed having abuse training. She verbalized she didn't mean it to come out in a bad way, and she didn't mean to shut Resident #1 up. GNA #13 verbalized because of Resident #1 reaction to her telling him to shut-up, it was verbal abuse. The resident didn't mean to shout at her. The resident was complaining about the facility, and she told him to calm down and shut up. GNA #13 verbalized the resident was anxious frequently and she was trying to calm the resident down. GNA #13 reported in their culture they try to reflect inward when having issues. She told the resident to calm down, shut up, and look inward to figure things out; the resident asked for her opinion. GNA #13 did not report Resident #1 concerns to the nurse, or a supervisor nor was the incident<br><br>(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 |
|---|---|---|

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 215022 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 02/26/2026 |
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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | reported. On 02/20/26 at 10:53 am during an interview with Director of Nursing (DON) #2 the surveyor asked, how did he/she find out about the allegation of abuse. DON #2 verbalized they received a phone call from the supervisor and came to the facility to complete the investigation. Interviews were completed by staff and residents. That day they were able to complete the investigation; it was more of a cultural misunderstanding between them two. The resident asked the GNA a question; it was a cultural misunderstanding; what they would do in that situation. It was a response to a question. The resident was a two-person assist; GNA #14 was in the room assisting as well. The surveyor verbalized the investigation did not mention another GNA was present during the alleged incident nor was there a statement from the employee. Also, GNA #13 did not mention GNA #14 was in the room. On 02/20/26 at 2:11pm during a telephone interview with Resident #1 the surveyor asked the resident if there was an incident when a GNA told him to shut-up. Resident #1 verbalized GNA #13 told them to shut-up; he/she was in the chair and wanted to get back in bed. The GNA had to get the lift to put them in bed. The surveyor asked was another person in the room. The resident verbalized yes, it was a male in the room. The other GNA heard GNA #13 tell them to shut-up and made a gesture with their hand to say that should not have been said. The surveyor asked the resident did he/she ask GNA #13 for advice. Resident #1 replied no and they did not want that to happen to someone else. |

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| F 0607<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement policies and procedures to prevent abuse, neglect, and theft.<br><br>Based on record review and interview, it was determined that the facility failed to develop and implement abuse policies and procedures. This was evident for 1 of 3 abuse policies reviewed. The findings include:On 2/24/26 at 1200 PM a review of the facility's Abuse, Neglect, and Exploitation policy revealed it was implemented on 2/2015 and reviewed/revised on 11/2023. Section IV. Identification of Abuse, Neglect, and Exploitation #1 read that it was considered an abuse allegation when reported by a resident, staff, or family. Section V. Investigation of Alleged Abuse, Neglect, and Exploitation, letter A read that an immediate investigation was warranted when there was suspicion of abuse, VI. Protection of the Resident letter D read that room or staffing changes were to be made, if necessary to protect the resident (s) from the alleged perpetrator. Section VII. Reporting/Response, letter A read the facility would have written procedures that included: 1. reporting of all alleged violations to the Administrator, state agency, adult protective services, and all other required agencies. 1a. immediately, but no later than 2 hours after the allegation is made. During a review of the facility's investigation file for the facility reported incident #2725522 on 2/24/26 at 10:00 AM it was revealed on the initial report form that an allegation of abuse for Resident #5 was reported to Registered Nurse (RN) #11 on 1/23/26 at 8:30 PM. The administrator was not made aware of the abuse allegation until 11 hours later by the DON on 1/24/26 at 7:30 AM. According to the report the resident told the nurse that Geriatric Nursing Assistant (GNA) #12 had rolled him/her over in bed causing them to hit their head on the bedrail. Further review revealed the email confirmation the report was submitted to the state agency on 1/24/26 at 9:25 AM by the Director of Nursing (DON). An interview with the DON on 2/25/26 at 11:32 AM revealed that she was not informed of the allegation of abuse until the following morning 1/24/26 at approximately 7:00 AM. She stated that when she interviewed RN #11 the nurse reported that she was not sure if this was an allegation of abuse. The DON reported that the employees know they can call her at any time, however this nurse failed to call immediately. Furthermore, GNA #12 continued to work the rest of her shift until 11:00 PM with vulnerable residents. On 2/25/26 at 12:13 PM the concerns were reviewed with the Nursing Home Administrator who offered no rationale for the deficient practice. Cross Reference: F609 and F610 |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>Based on record review and review of the facility's investigation and interview it was determined that the facility staff failed to report allegations of abuse within the required timeframe. This deficient practice was evidenced in 2 (Residents #3, #5) of 5 residents reviewed for abuse allegations. The findings include:<br><br>1. On 2/24/26 at 1200 PM a review of the facility's Abuse, Neglect, and Exploitation policy revealed it was implemented on 2/2015 and reviewed/revised on 11/2023. Section IV. Identification of Abuse, Neglect, and Exploitation #1 read that it was considered an abuse allegation when reported by a resident, staff, or family. Section VII. Reporting/Response, letter A read the facility would have written procedures that included: 1. reporting of all alleged violations to the Administrator, state agency, adult protective services, and all other required agencies. 1a. immediately, but no later than 2 hours after the allegation is made.<br><br>On 2/24/26 at 10:00 AM a review of the facility's investigation file for the facility reported incident #272552 revealed an initial report form. According to the initial report Resident #5 reported to Registered Nurse (RN) #11 that geriatric nursing assistant (GNA) #12 had rolled him/her over in bed and hit the resident's head on the bedrail on 1/23/26 at 8:30 PM. However, she failed to report the allegation of abuse to the Director of Nursing (DON) until 1/24/26 at 7:30 AM, 11 hours later. The confirmation email revealed the DON sent the allegation of abuse to the State Agency (SA) on 1/24/26 at 9:25 AM.<br><br>An interview with the DON on 2/25/26 at 11:32 AM revealed that her expectation was for staff to report allegations of abuse to her as soon as possible. She stated that the nurse was unsure it was an allegation of abuse, but once she reported the incident to the DON, she was informed it was an allegation of abuse. The DON stated that she reported it to the SA once she was made aware.<br><br>The concerns were reviewed with the Nursing Home Administrator on 2/25/26 at 12:13 PM.<br><br>Cross Reference: F607 and F610<br><br>2. On 02/20/26 at 2:09 pm the surveyor received a copy of the email that was received by the facility when the final report of the investigation related to Resident # 3 was submitted. The facility staff submitted an allegation of abuse on 10/21/25. According to the email received from Administrator #1 on 02/20/26 at 2:09 pm, the 5-day final report was submitted on 10/29/25. Five working days after the initial report was submitted would have been 10/28/25. The report was submitted to the state agency a day late.<br><br>On 02/20/26 at 2:47 pm during an interview with Director of Nursing (DON) #2 the surveyor asked what timeframe the results of an investigation should be submitted to the state agency. DON #2 verbalized they have 5 days to submit the follow-up investigation results. |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Respond appropriately to all alleged violations.<br><br>Based on the review of the facility's investigations and interviews it was determined that the facility staff failed to complete thorough investigations of incidents reported to the state agency and failed to ensure that residents were safe by allowing an alleged abuser to continue to work with vulnerable residents. This deficient practice was evidenced in 2 (Residents #1 and #3) of 3 facility reported incident investigations reviewed during the complaint survey.The findings include:<br><br>1. On 02/20/26 at 10:53 am during an interview with Director of Nursing (DON)#2 the surveyor asked, how did they find out about the allegation of abuse concerning Resident #1 for the incident that occurred on 10/02/25 during the 3:00 pm – 11:00 pm shift and was reported by the resident to staff on 10/05/25 during 7:00 am – 7:00 pm shift. DON #2 verbalized receiving a phone call from the supervisor. After receiving the phone call, the allegation was reported to Administrator #1 and he/she came to the facility to start the investigation. Interviews were conducted of the staff and residents. That same day (10/5/25) they were able to resolve it. Geriatric Nursing Assistant (GNA) #13 on the day of the incident was providing care to Resident #1 who was a two-person assist. GNA #14 was in the room assisting. The surveyor confirmed GNA #14 was in the room during the allegation of verbal abuse. The surveyor made DON #2 aware there was not a statement in the investigation from GNA #14. DON #2 verbalized speaking with GNA #14 about the incident.<br><br>2. On 02/19/26 at 10:18 am during an interview with Director of Nursing (DON)#2 the surveyor asked to explain their process of investigating complaints or incidents related to the residents or an allegation of abuse. DON #2 verbalized they get statements from the resident, the alleged perpetrator, other resident, and employees; they remove the staff pending investigation.<br><br>On 02/20/26 at 10:45 am a review of Licensed Practical Nurse (LPN) #15 statement revealed DON #2 did not ask LPN #15 if he/she called Resident #3 a cranky old [expletive].<br><br>On 02/20/26 at 11:22 am during an interview with Licensed Practical Nurse (LPN) #15 the surveyor asked to tell what happened with Resident #3. LPN #15 verbalized he/she can't tell the surveyor what happened because they didn't know anything happened. There were never any problems with Resident #3; Resident #3 always told him/her they were one of the nicest people working in the facility. The surveyor made LPN #15 aware the resident accused them of calling the resident a cranky old [expletive]. The surveyor asked LPN #15 did they call Resident #3 a cranky old [expletive]. LPN #115 denied calling the resident by the expletive.<br><br>On 02/20/26 at 2:39 pm during an interview with DON #2 the surveyor asked why she didn't ask LPN #15 did they call the resident a cranky old [expletive]. DON #2 verbalized the resident said it happened around medication administration when he/she heard the nurse say that. He/she asked LPN #15 open-ended questions concerning the medication administration interaction with the resident.<br><br>3. On 2/24/26 at 1200 PM a review of the facility's Abuse, Neglect, and Exploitation policy revealed it was implemented on 2/2015 and reviewed/revised on 11/2023. Section IV. Identification of Abuse, Neglect, and Exploitation #1 read that it was considered an abuse allegation when reported by a resident, staff, or family. Section V. Investigation of Alleged Abuse, Neglect, and Exploitation, letter A read that an immediate investigation was warranted when there was suspicion of abuse, VI. Protection of the Resident letter D read that room or staffing changes were to be made, if necessary to protect the resident (s) from the alleged perpetrator.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A review of the facility's investigation file for the facility reported incident #272552 on 2/24/26 at 10:00 AM revealed on the initial report from that Resident #5 reported an allegation of abuse on 1/23/26 at 8:30 PM to Registered Nurse #11. The resident reported that geriatric nursing assistant (GNA) #12 had rolled him/her over in the bed and hit their head on the bedrail.<br><br>A review of GNA #12's timesheet revealed that she clocked out until 11:00 PM on 1/23/26, which indicated she worked 2 1/2 hours after the allegation of abuse. On 1/24/26 she came in at 7:30 am and clocked out at 8:30 am at which time she was suspended as reported by the Director of Nursing (DON) in a later interview.<br><br>An interview with the DON on 2/25/26 at 11:32 AM revealed RN #11 failed to notify her of the allegation of abuse immediately. She stated the nurse should have called even if she was not sure it was an abuse allegation. She stated that was the reason that the GNA was allowed to continue to work that evening because she would have suspended the GNA immediately.<br><br>The concerns were reviewed with the Nursing Home Administrator on 2/25/26 at 12:13 PM who offered no rationale for the deficient practice.<br><br>Cross Reference: F607 and F609 |

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| F 0620<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Many | Not require residents to give up Medicare or Medicaid benefits, or pay privately as a condition of admission; and must tell residents what care they do not provide.<br><br>Based on record review and interview, it was determined that the facility admission agreement failed to include special characteristics and service limitations related to a kosher diet, and requested residents waive their rights as well as waive potential facility liability for personal property losses. The findings include:On 2/19/26 at 1:51 PM a review of the admission packet revealed the admission Agreement. A review of this document failed to reveal information regarding the facility's kosher diet. In addition, the document requires the resident and sponsor agree to not hold the facility responsible for injury or harm that could have been avoided if they had hired a private duty nurse.Further review revealed a Risk Acknowledgement. This form outlined the facility was not responsible for stolen, lost, or damaged personal property and were not responsible for the development of pressure sores, despite regulatory requirements prohibiting waiver of potential facility liability for losses of personal property and regulatory requirement to provide a quality of care that included treatment and services to prevent pressure sores. A separate welcome packet included a copy of the Always Available Menu included in the packet which indicated that they served tuna salad, egg salad, turkey sandwich, bologna sandwich, and pastrami sandwiches along with some other items. At the bottom of the sheet it noted, Any alternate chosen must reflect the kosher appropriate menu option (diary for dairy meal, meat for meat meal.) However, there was no other mention of the special dietary considerations in the welcome packet.An interview with the Hospital Liaison on 2/20/26 at 9:34 AM revealed that she was the person who talked to potential residents in the hospital. She stated that they do not let the residents and/or resident's family know prior to admission and in writing that they follow a kosher diet. She stated that she may mention it but does not go into any detail as to what it means unless they ask for further information. She stated, Food is food and it should not make a difference that meat and dairy cannot be served in the same meal.The Nursing Home Administrator (NHA) was asked to provide proof that the admission policy/agreement was approved at the time of the change in ownership on 2/24/26 at 10:06 AM via a phone call and it was clarified with him on 2/24/26 at 10:14 AM. He was asked on 2/25/26 at 12:19 PM for the information. However, he failed to provide the evidence.On 2/26/26 at 12:33 PM an interview with the NHA revealed he was unable to provide proof that the admission agreement was approved during the change in ownership in 2017 and confirmed that residents were not informed in writing prior to admission that they followed a kosher diet. He stated that it may be included in a brochure, but that he cannot be certain that it was given to every resident. In addition, the surveyor had asked for all information that was provided before and at the time of admission and he failed to provide such a brochure. He offered no rationale as to why the admission agreement and risk acknowledgement was not in compliance with the regulatory requirements. |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews it was determined that the facility staff failed to clarify a physician's order, failed to follow a physician's order, and failed to ensure a resident received their medication as ordered. This deficient practice was evidenced in 1 (#9) of 5 medical records reviewed during the complaint survey.The findings include:1. On 02/25/26 at 11:38 am a review of Resident #9's electronic health record (EHR) revealed a change in condition note was written on 12/23/25 at 1:38 pm indicating the resident was diagnosed with Influenza A. An order was written on 12/23/2025 1:27 pm for Tamiflu Oral Capsule 30 MG Give 1 capsule by mouth two times a day (BID) for Flu for 5 Days; the order was discontinued on 12/23/2025 10:51 pm. The resident never received the medication. The surveyor received a note indicating the physician was made aware on 12/23/25 at 10:50 pm. Another order was written on 12/23/25 at 10:51 pm Tamiflu 30 MG Give 1 capsule by mouth two times a day for Flu for 5 Days. According to the medication administration record (MAR) the resident did not receive the medication.On 02/26/26 at 9:55 am the surveyor received a note indicating the MD was made aware and the medication was not received on 12/23/25 at 10:50 pm. The facility staff did not notify the physician after the medication was not received the following day; there was no documentation to verify the pharmacy was made aware.On 02/25/26 at 1:04 pm during an interview with LPN Unit Manager #10, the surveyor made them aware the resident tested positive for Influenza A on 12/23/25, was ordered Tamiflu but never received the medication. LPN Unit Manager #10 verbalized typically get medications within 24 hours. STAT medications in a 4-hour window and if the order is placed by 2 pm they will receive the medication by midnight.On 02/25/26 at 3:08 pm during a telephone interview with Physician # 20 the surveyor reported Resident #9 tested positive for Influenza A and was ordered Tamiflu x 5 day, but the resident did not receive the medication. Physician #20 verbalized the patient was in the facility a couple of months ago and was not aware they didn't get the medication prescribed. Physician #20 did not specifically recall being notified that Tamiflu was not administered. 2. On 02/25/26 at 12:21 pm further review of Resident #9's EHR revealed the facility staff received a critical lab result on 12/21/25 at 11:44 pm. The resident's blood culture in the aerobic bottle tested positive for gram + cocci. The resident was ordered on 12/22/25 at 10:22 am to receive Vancomycin 750 mg IV BID for bacteremia x 14 days. The resident received three doses. When a Vancomycin trough level was reported on 12/24/25 at 9:45 am revealed a level of 20 ug/ml which was reported as high. The Vancomycin dose was decreased on 12/24/25 at 11:02 am to Vancomycin 500 mg IV BID x 14 days. The resident did not receive any doses of the medication prior to being sent to the emergency room on [DATE]. On 02/26/25 at 9:55 am the surveyor received a note indicating the nurse notified the physician about the missed dose on 12/24/25 at 6:00 am. There was no documentation to verify the physician, or pharmacy were made aware the resident did not receive the lower dose of Vancomycin 500 my IV BID x 14 days. On 02/25/26 at 2:14 pm during an interview with LPN Unit Manager #10 who reported Resident #9 got three doses of Vancomycin 750 mg, a trough was done and the dose needed to be decreased. They didn't get the lower dose and they never received Tamiflu. On 02/25/26 at 3:04 pm during a telephone interview with Nurse Practitioner (NP) #19 the surveyor asked are they aware the resident did not receive the decreased dose of Vancomycin 500 mg IV that was ordered on 12/24/25 at 11:02 am. NP #19 verbalized not being aware the resident did not receive the intravenous antibiotic. The surveyor reported the resident was diagnosed with Influenza A but did not receive Tamiflu as ordered. NP #19 verbalized not being aware the resident did not receive Tamiflu as ordered. 3. On 02/25/26 at 11:15 pm a review of Resident #9's EHR revealed an order for Sodium Chloride (Na CL) Intravenous Solution 0.9% q shift, every shift for IV fluid<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | and to document the amount of cc given during the entire shift. The order for IV fluids failed to include how many milliliters of IV fluids the resident should receive. The order date was 12/08/25 2:57 pm and the D/C date was 12/10/25 at 6:55 am. The surveyor made DON #2 the order was incomplete, and they nurse should have clarified how many ml the resident should receive each shift. On 12/16/26 at 2:46 pm an order was written for the resident to receive NaCl 1 Liter IV in the evening every Monday, Wednesday, Friday for high ostomy output/dehydration and to use 100 ml/hr IV, document the amount of cc given during the entire shift in numbers. A review of the medication administration record revealed (MAR) the nurses were not documenting the amount of IV fluids the resident received. During an interview with DON #2 they verbalized the amount of fluids the resident received should be written in the notes. On 02/25/26 at 3:30 pm during an interview with LPN Unit Manager #10 the surveyor asked if a resident's medication is not available on site, what do they do? LPN Unit Manager #10 verbalized if they can't get the medication prescribed they would get something that is equivalent and call the pharmacy to get a STAT dose. |

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|---|---|---|---|
| | 215022 | A. Building<br>B. Wing | 02/26/2026 |

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

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| F 0803<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>Based on record review and interview it was determined that the facility staff failed to provide a resident with a food preference because it could not be offered during a Jewish milk day. This deficient practice was evidenced in 1 (#7) of 2 resident records reviewed for food preferences during the complaint survey.The findings include:On 02/19/26 at 2:25 pm a review of a complaint concerning Resident #7 nutritional needs revealed the resident requested to receive a turkey or tuna sandwich daily, but the request was not honored during their stay for rehabilitation.On 02/26/26 at 10:22 am a review of Resident #7 food preferences revealed the resident was prescribed a regular diet. On Sunday, Tuesday, Thursday, and Saturday the resident was supposed to receive a chicken salad sandwich during lunch. On Monday, Wednesday, and Friday the resident was supposed to receive a turkey sandwich. There was no food preference for a tuna sandwich.On 02/26/26 at 12:28 pm during an interview with Certified Dietary Manager #26 the surveyor asked if a resident requested a turkey or tuna sandwich daily would the kitchen staff be able to honor that request? CDM #26 verbalized the resident could receive the turkey during a meat meal and tuna during a dairy or meat meal, but not every day. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interview, it was determined that staff failed to provide dietary services in a safe and sanitary environment. This deficient practice was evident during observations in the kitchen and the Nourishment Room on Sudbrook unit during the complaint survey. The findings include:<br><br>1. On 02/18/26 at 8:32 am during observation rounds on the unit Sudbrook, while in the Nourishment Room the surveyor observed an opened container of Amish Style Potato Salad and [NAME] Honey Uncured Ham. Both were dated 01/26/26. Vanilla ice cream was observed spilled in the freezer, and there were multiple spills in the refrigerator, and two unlabeled and undated small containers of applesauce.<br><br>On 02/20/26 at 10:06 am during an interview with LPN Unit Manager #5 the surveyor asked what department was responsible for monitoring the refrigerator temperatures, keeping the refrigerator clean, and ensuring the food was dated and labeled. LPN Unit Manager #5 verbalized the environmental services department was responsible for keeping the refrigerator clean but they all should monitor what's in the refrigerator; the refrigerator is for the residents. The temperature log was kept in the white binder on the crash cart.<br><br>On 02/20/26 at 10:35 am the surveyor asked to review the refrigerator temperature log on Sudbrook. A review of the Fridge Temperature Log for the month of February 2026 revealed that the temperature was not recorded on 02/14, 02/15, and 02/20/26. A review of the Fridge Temperature Log for December 2025 revealed there was not a temperature recorded on 12/12, 12/17, 12/24, 12/25, 12/26, 12/27, 12/28, and 12/31/25. The surveyor showed LPN Unit Manager #5 the dates where the refrigerator temperatures were not recorded.<br><br>On 02/26/26 at 11:50 am during EVS Director #9 he/she verbalized they check the refrigerator on a weekly basis; he/she usually checks it on Monday or Tuesday the latest. EVS is responsible for cleaning the refrigerator. They discard items that are outdated or without a date. The temp is checked once a week and a report is given to Administrator #1 on the Quality Assurance report.<br><br>2. A tour of the kitchen on 2/18/2026 at 12:32 PM revealed the following:<br><br>a. Plastic container sitting under the sink drain with water in it,<br><br>b. Floor tiles were broken,<br><br>c. A fan that vented to the outside was covered in dust,<br><br>d. A window air conditioning unit that was dusty and leaning to the right side,<br><br>e. There was a stack of bread crates sitting on the floor with loaves of bread on them,<br><br>f. The dishwashing area had standing water on the floor,<br><br>In the refrigerator there were several containers of applesauce, fruit and Jello that were not dated sitting on trays. There were containers of egg salad, potato salad, and chicken salad with no dates on them. There were undated, opened juice containers. There were boxes of food stored on the floor.<br><br>(continued on next page) |

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

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | In the freezer there were boxes stored on the floor. The fans had condensation and ice buildup on the ceiling.<br><br>An observation of the dry storage area on 2/18/26 at 12:47 PM revealed:<br><br>a. There was a bag of sugar sitting on the floor.<br><br>c. There were lids and debris on the floor.<br><br>d. An air conditioning unit that was vented through the wall had 3 boxes piled on tubing.<br><br>e. There were bags of portion cups stored on the floor.<br><br>On 2/18/26 at 1:00 PM an interview with [NAME] #23 revealed they had received a shipment of boxes that day. When shown the other supplies on the floor he acknowledged that they were not from the recent delivery.<br><br>On 2/18/26 at 1:02 PM dietary Staff #24 was observed to be preparing lunch and failed to have a hair and beard restraint on.<br><br>On 2/19/26 at 1:30 PM an observation of dietary Staff #25 was observed preparing food portion cups for storage and failed to have on a hair and beard restraint.<br><br>An interview with the Dietary Manager on 2/26/26 at 12:03 PM revealed he was responsible for ensuring the kitchen was cleaned and maintained, and that staff were wearing the appropriate hairnets and beard nets. He stated that he was addressing maintenance issues with the Maintenance Director, such as the leaking sinks, standing water on the floor, and the broken tiles due to environmental rounds that were completed on 2/3/26. He later provided an email outlining these concerns. When asked about the cleanliness of the kitchen he stated that he was aware, however, had not addressed the issue. He stated that he was having issues with staff wearing the hair and beard restraints but had not addressed it with them.<br><br>The concerns were reviewed with the Nursing Home Administrator on 2/26/26 at 12:30 PM. |

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| F 0814<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Dispose of garbage and refuse properly.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews it was determined that the facility staff failed to ensure the waste refuse containers were closed and not overflowing with waste. This deficient practice was evidenced in 4 of 4 waste containers observed on the facility's property during the complaint survey.The findings include:On 02/24/26 at 1:28 pm while in the dining room located on Mount [NAME], the surveyor lifted the shade on the second window and observed 4 large waste containers. The top lid of waste container #8320 was opened and large bags of rubbish were exposed at the top. Also, a clear white bag was hanging off the left side of the waste container. The left sliding door of the waste container #8319 was opened and a clear waste bag was hanging out the side. The top lid of waste container #8213 was opened with brown boxes and waste bags exposed. The lid to waste container #8148 was opened with clear waste bags exposed and hanging over the front of the large waste container. There was waste on the ground on both sides of the container. On 02/24/26 at 1:24 pm during an interview with Maintenance Director #8, the surveyor asked what department is assigned to management the waste containers outside Maintenance Director #8 verbalized the Environmental Services Department oversees the dumpsters; the dumpsters are emptied Monday, Wednesday, and Friday. EVS oversees making sure the areas around the dumpsters are clean. On 02/25/26 at 1:24 pm during an interview with EVS Director #9 he/she verbalized the porters were supposed to know when the dumpsters are full to close them after they put the trash in. All departments use the dumpsters, but the porters are responsible for ensuring they are closed. |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>On the review of the electronic health record and interview it was determined that the facility staff failed to document when a resident received activities of daily living (ADL) assistance. This deficient practice was evidenced in 1 (#6) of 5 resident records reviewed during the complaint survey.The findings include:On 02/25/26 at 8:39 am a review of Resident #6 ADL tasks for the months of December 2025 and January 2026 revealed there were multiple GNA tasks that were not completed during both months. On 12/24 & 12/25/25 (11 pm - 7 am), 12/26/25 (7am- 3 pm), and 12/31/25 (11 pm - 7am) there was no documentation to verify if the resident received personal hygiene care. On 12/24 & 12/25/25 (11 pm - 7am) 12/26/25, (7am-3pm), and 12/31/25 (11pm-7am) there is no documentation to verify the resident was turned and repositioned. On 01/03/26 (3pm-11pm) there was no documentation to verify the resident was turned and repositioned. On 01/03, 01/11, 01/18 during 11pm - 7am shift there was no documentation to verify if the resident was bathed. There was no documentation on 01/03, 01/11, and 01/18/26 during 3pm-11pm shift to verify if the resident had an episode of bladder/bowel incontinence and if the resident received personal hygiene. On 02/25/26 at 9:42 am the surveyor reviewed Resident #6's ADL care documentation with LPN Unit Manager #5, the surveyor asked was the staff expected to document ADL care each shift. LPN Unit Manager #5 verbalized the expectation was for the documentation to be done; the documentation should have been completed by the end of the shift. Once the task is completed they should document but if not it should be done by the end of the shift. When a resident has an incontinence episode there should be documentation in the boxes. The clinical staff is responsible for ensuring the staff completes the documentation of the care that was provided. Chart reviews are done the day after the care was provided. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews it was determined that the facility staff failed to maintain infection control practices. This deficient practice was discovered during three observations of linen carts and shower rooms during the complaint survey.The findings include:On 02/18/26 at 8:31 am during observation rounds the surveyor observed a linen cart outside of room [ROOM NUMBER] with a tube of cream, shower gel, a fan, and a bag of wash cloths on top on the linen cart.On 02/18/26 at 8:43 am the surveyor observed an uncovered linen cart outside of room [ROOM NUMBER].On 02/20/26 at 10:25 am the surveyor made Unit Manager #5 aware of the uncovered linen cart and the linen cart with items on top. LPN Unit Manager #5 verbalized the linen cart should have been covered and the items should not have been on top of the linen cart.On 02/20/26 at 10:30 am while in the shower room on Sudbrook with LPN Unit Manager #5 the surveyor observed a used washcloth on the grab bar in the shower stall and two used washcloths and a towel on the floor in front of the first shower stall.LPN Unit Manager # 5 verbalized the Geriatric Nursing Assistants are supposed to clean up after using the shower room. To their knowledge Environmental Services cleans the shower room daily. |

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| F 0921<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interview it was determined that the facility staff failed to maintain the building in a safe, comfortable, homelike environment. This deficient practice was discovered during the complaint survey.<br><br>The findings include:<br><br>1. On 02/18/26 at 8:30 am during observation rounds, the surveyor entered the Nourishment Room and observed damaged drywall on two walls. The surveyor opened the cabinet and the door flung open as the bottom hinge was broken. The cabinet under the sink was had water damage and there was a hole in the bottom of the cabinet.<br><br>On 02/18/26 at 8:35 am the surveyor observed an electric outlet with two red wires and two black uncapped wires hanging out of an electrical box in the shower room on Sudbrook.<br><br>On 02/18/26 at 8:36 am while in the supply room located on Sudbrook, the surveyor observed a package of clear cups, a blue basket, and plumbing tools and parts on a blanket under the sink.<br><br>On 02/18/26 at 8:46 am the surveyor observed a broken soap dispenser in the shower room on [NAME]. The front of the soap dispenser cover was on a shower bed inside the stall.<br><br>On 02/20/26 at 9:55 am the surveyor showed LPN Unit Manager #5 the maintenance concerns on the unit Sudbrook. The surveyor asked how maintenance concerns are communicated to the maintenance department. LPN Unit Manager #5 verbalized there is a maintenance binder on each unit or the staff could communicate the issues to maintenance directly. The maintenance and Environmental Services departments check the binders daily. The surveyor asked who ensures the maintenance issues are addressed. LPN Unit Manager #5 verbalized the clinical team would follow up the next morning during their morning meeting. The surveyor asked if the maintenance concerns were put in the binder. LPN Unit Manager #5 verbalized the maintenance concerns were not documented in the binder. Nobody looked into the cabinet besides the surveyor.<br><br>On 02/20/26 at 11:10 am Director f Nursing # 2 verbalized there was a maintenance book on each unit and manager's report maintenance issues when they meet. They report issues during the morning meeting. Administrator #1 will follow up to ensure the issues were addressed.<br><br>On 02/24/26 at 1:12 pm during an interview with Maintenance Director # 8 the surveyor asked is there a preventative maintenance schedule. Maintenance Director #8 verbalized they have a set of rooms to check every quarter; they check call bells to see if they are working properly outside of the door and the nurse's station. There is only one person in the maintenance department. The nourishment and supply rooms are not rooms that are regularly checked; the only way he/she would know if someone reports the issue. There is a yellow maintenance book on each nurse's station that gets check every day or every other day depending on how his/her day is going. The book is checked in the morning. There is not a checklist to verify repairs were made.<br><br>On 02/24/26 at 1:30 pm while in the dining room on Mount [NAME] the surveyor lifted the shade of the middle window and cold air was coming from the window. After further inspection the surveyor noticed the upper and lower parts of the window had a large gap which allowed the cold air from outside<br><br>(continued on next page) |

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| F 0921<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | to enter the room. There were two other windows in the room which had large gaps in the window which allowed the cold air to enter the room.<br><br>On 02/24/26 at 2:05 pm the surveyor demonstrated to Maintenance Director #8 the three set of windows with a large gap which allowed cold air into the dining room on Mount [NAME]. Administrator #1 was present at that time. After surveyor intervention Maintenance Director #8 used a screwdriver to align the three set of windows; afterwards the gap in the windows were resolved.<br><br>2. On 2/18/26 at 8:00 AM an observation of the facility parking lot revealed that there were discarded face mask, gloves, water bottles, plastic cups, and other debris in the parking lot.<br><br>A second observation on 2/19/26 at 8:36 AM revealed that there were mask, gloves, plastic bottles, plastic straws, and other debris laying all over the parking lot and along the curb. Along the right side of the parking lot was a tree line that had plastic bags stuck in the trees and bushes, plastic cups, paper, and other debris scatter. The area in front of the building near the front door had mask, water bottles, plastic bags, broken plastic pieces lined against the building. The porch area at the entry door had a trashcan with debris laying near it, a broken orange snow shovel, and black plastic piece, plastic bags, and paper laying in the grass to the left.<br><br>On 2/19/26 at 10:00 AM met with the Nursing Home Administrator (NHA), Maintenance Director, and EVS Director. When asked who was responsible for cleaning up the debris in the parking lot. EVS stated that it was housekeeping's responsibility.<br><br>Reviewed findings with the EVS Director with the NHA present on 2/19/26 at 10:03 AM by walking around the parking lot and showing her the debris. She stated that she assigns a porter everyday to clean the parking lot area. When asked who monitors if it was done or not, she stated that she does. She stated that she has not checked the area since they had snow. |