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	04/27/2026

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on complaint, reviews of a closed clinical record and administrative records, and staff interviews, it was determined that the facility nursing staff failed to follow the physician's order for specific pulse and blood pressure parameters before administering cardiac medications. This was evident for 1 (Resident #7) of 7 residents reviewed during a complaint survey. The findings include: Review of Resident #7's closed clinical record on 04/22/26 revealed that Resident #7 was admitted to the facility on [DATE] with diagnoses that include a stroke, left eye blindness, and Alzheimer's type dementia. Resident #7 and had been deemed incapable of making all medical decisions by 2 attending physician on 12/11/25 and 12/12/25. Further review of Resident #7's closed clinical record on 04/2/26 revealed a physician's order dated 12/17/2025 at 5 pm instructing the nursing staff to administer the medication, Nifedipine, 60 milligrams (mg), extended release, orally, every 24 hours, at bedtime (9 pm) for hypertension. Hold the medication if the systolic blood pressure (SBP) is less than 110 or the heart rate is lower than 60 beats per minute. A review of Resident #7's December 2025 medication administration records (MAR) on 04/2/26 revealed the nursing staff failed to withhold the dose of Nifedipine on the following date and time: 12/20/25, 9 pm dose, with a documented pulse of 59 beats per minute. These findings were shared with the facility director of nurses (DON) and the facility Administrator at the exit conference on 04/27/26 at 5 pm.

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 04/27/2026
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)
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 observation, medical record review and staff interview, it was determined that the facility failed to provide supervision during a medication pass to ensure the medication was taken by the resident and remove the medication when it was refused. This was observed for 1 (Resident #6) of 7 residents reviewed during a complaint survey. The findings include: During a tour of the facility on 04/23/26 at 5:15 pm, observation revealed 3 small round orange pills located in a medication administration cup on Resident #6's bedside table. Resident #6 was seated in the wheelchair which was next to Resident #6's bed and behind the bedside table. A staff member was observed assisting Resident #6 with the meal tray. After greeting, Resident #6 was asked if the medication sitting on the bedside table was their medication. Resident #6 stated that the medication was their blood pressure pills from this morning and that he/she refused to take the medication. Resident #6 stated that he/she documents every blood pressure the nursing staff obtain before the nurse would administer the medication. Resident #6 stated that his/her blood pressure this morning was 110/66 with a pulse of 68 beats per minute. Resident #6 stated that they interpreted the blood pressure reading as being to low and that he/she was instructed not to take her blood pressure medication if the blood pressure reading was low. RN #1 was made aware and observed the 3 pills sitting in front of Resident #6. The 3 pills were removed at that time. A review of Resident #6's medical record on 04/23/26 revealed a physician's order, dated 01/27/26, instructing the nursing staff to administer the blood pressure medication, Hydralazine, 25 milligram (mg) tablet, give three (3) tablets every 8 hours by mouth for Hypertension. Withhold the medication for a systolic blood pressure reading of less than 110 Hg/mm or a pulse rate less than 60. A review of Resident #6's April 2026 medication administration record (MAR) revealed that LPN #2 administered a dose of Hydralazine to Resident #6 at 6 am and documented a blood pressure of 110/66 and a heart rate of 68 beats per minute. Resident #6 was assessed on 4/15/26 with a BIMS score of 15/15. The BIMS (Brief Interview for Mental Status) score is a 0-15 point tool used in healthcare, particularly long-term care, to assess cognitive function, with higher scores indicating better cognition. It evaluates immediate recall, temporal orientation, and short-term memory. A score of 13-15 indicates intact cognition, 8-12 moderate impairment, and 0-7 severe impairment. A review of the facility policy for Medication Administration on 04/23/26 revealed a compliance guideline, #19, that instructs the nursing staff to report and document any adverse side effects or medication refusals.