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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365094	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/19/2024
NAME OF PROVIDER OR SUPPLIER King David Post Acute Nursing & Rehabilitation LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 27100 Cedar Rd Beachwood, OH 44122	

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39973 Based on observation, interview, record review and review of facility policy the facility failed to ensure call lights were answered in a timely manner and failed to ensure staff was not taking personal phone calls while a resident was waiting for assistance. This affected three residents (#285, #116, and #139) out of five residents reviewed for call light response and had the potential to affect all residents residing in the facility. The facility census was 285. Findings include: 1. Review of the medical record for Resident #285 revealed an admitted [DATE] with diagnoses including Parkinson's disease, diabetes, morbid obesity, urinary incontinence, and heart failure. Review of the care plan dated 06/19/19 revealed Resident #285 was at risk for falls due to anxiety disorder, depression, and decline in functional status. Interventions included be sure the call light was within reach, encourage resident to use it, and promptly respond to all requests for assistance. Review of the care plan dated 09/11/19 revealed Resident #285 had an activities of daily living (ADL) self-care performance deficit requiring assistance with ADL due to Parkinson's, mood, impaired mobility, and incontinence. Interventions included mechanical lift with two-staff assistance for transfers, assistance of staff with dressing, personal hygiene, bed mobility, and bathing. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #285 had impaired cognition. (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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 06/12/24 from 10:03 A.M. to 10:39 A.M, revealed Resident #285's call light was activated. Agency State tested Nurse Aide (STNA) #620 was observed sitting at a desk at the end of Resident #285's hallway. After several minutes she got up from the desk and proceeded down the hallway passing Resident #285's room; the call light that remained on. This surveyor asked who was assigned to care for Resident #285, and Agency STNA #620 stated that she did not know and that she was from agency. Agency STNA #620 proceeded to pick up linen off the floor that was contained in a clear trash bag and place it into a pink laundry cart. Agency STNA #620 then started to talk aloud having a conversation as she had an earpiece in place. She proceeded to walk down the hallway towards the desk again continuing to have a conversation passing Resident #285's room as her call light continued to go off. At 10:26 A.M. Agency STNA #620 continued to carry on a conversation aloud as she remained in the hallway not answering Resident #285's call light. Observation on 06/12/24 at 10:39 A.M. Registered Nurse (RN) #621 answered Resident #285's call light after it had been activated for 36 minutes. Interview on 06/12/24 at 10:39 A.M. with RN #621 revealed Resident #285 stated she was not able to find her call light, and that her television was not working. RN #621 revealed she was not aware Resident #285's call light was on for 36 minutes as she was just one of the nurses helping on the floor. Interview on 06/12/24 at 10:45 A.M. with Resident #285 revealed she was cognitively impaired as well as spoke a different language. She was unable to provide details regarding her call light, and she just kept pointing to her television. Interview on 06/12/24 at 10:55 A.M. with STNA #623 and STNA #622 revealed they were the other two aides on the unit that Resident #285 resided on, and they had been in the shower room giving a shower to another resident for the last half hour. They revealed Agency STNA #620 should have answered Resident #285's call light since they were not on the floor. Interview on 06/12/24 at 11:03 A.M. with Agency STNA #620 (with RN #621 and Assistant Director of Nursing (ADON)/ RN #600 present) revealed that she did not answer Resident #285's call light as Resident #285 was not her resident, and she had her own residents to care for and get up. ADON/ RN #600 educated Agency STNA #620 that all residents were her responsibility, and if a resident's call light was ringing that she needed to answer the call light. Agency STNA #620 denied being on her personal phone having a conversation while on the hallway but admitted to having an earpiece in place. Interview on 06/12/24 at 11:10 A.M. with ADON/ RN #600 verified staff should not be on their phones including speaking through an earpiece while on the unit. She verified that she had previously warned Agency STNA #620 about being on her phone while on the unit. She also verified call lights should be answered timely, and 36 minutes was not timely. Interview on 06/12/24 at 2:25 P.M. with President and Chief Operating Officer #601 revealed the facility did not have a cellphone policy regarding staff being on their phones while on the units but stated obviously they should not be using their personal phones on the floor. (continued on next page)

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	365094	A. Building B. Wing	06/19/2024

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Interview on 06/13/24 at 8:17 A.M. with Resident #116 who also stated he was the resident council president revealed that lately staff had not been answering his call light timely. He revealed at times his call light was not answered for over an hour, which he felt was way too long. He revealed often staff would answer his call light and state they would be back but then never come back, especially when he requested to go to bed. He revealed he felt it was not right to have to wait over an hour just to have staff assist him to get into bed. 3. Interview on 06/13/24 at 9:01 A.M. with Resident #139 revealed she has had to wait over an hour to have her call light answered. She revealed often the staff would answer her call light, shut it off, and state they would be back to complete the requested need, but that staff did not come back. She revealed she often had to call again and again just to get staff to assist her with her ADL, including incontinence care, getting out of bed, getting back in bed and/ or other needs. Review of the facility policy labeled Call System, Resident, dated September 2022, revealed residents were provided with means to call staff for assistance through a communication system that directly calls a staff member or centralized workstation. The policy revealed calls for assistance were answered as soon as possible. This deficiency represents non-compliance investigated under Complaint Number OH00154304.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39969 Based on record review, staff interview, and facility policy review the facility failed to ensure to obtain Pedialyte (oral electrolytes) ordered by the physician for Resident #226's resulting in nursing staff having to pay for the product with their own money. In addition, the facility failed to notify the physician when Pedialyte was unavailable, and staff were substituting it with Powerade. This affected one resident (#226) of five residents reviewed for dietary services. The facility census was 285. Findings include: Review of the medical record for Resident #226 revealed an admitted [DATE]. Diagnoses included non-infective gastroenteritis and colitis, malignant lung cancer, and autistic disorder. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #226 had intact cognition, no behaviors, and required set-up/clean up help with eating. The assessment also indicated the resident weighed 174 pounds, had no significant weight changes, and did not receive a mechanically altered or therapeutic diet. Review of the physician's orders for June 2024 revealed an active order for Pedialyte oral solution (oral electrolytes). Give six ounces by mouth three times a day for electrolyte supplement with a start date of 05/29/24. Review of the medication administration record (MAR) for May 2024 and June 2024 revealed the order was signed off as given on 05/29/24 through 06/17/24 except on 06/09/24 at 9:00 A.M. when Resident #226 refused and on 06/15/24 at 9:00 P.M. when the Pedialyte was not available (N/A). Interview on 06/17/24 at 2:47 P.M. with Registered Nurse (RN) #650 revealed it had been an ongoing issue with Resident #226 getting the Pedialyte. RN #650 stated they never received it from pharmacy and were told to go through dietary. Dietary sent something like Gatorade, and she could not recall the name of the product. RN #650 stated it got to the point that she talked with the resident's power of attorney (POA) and had gotten permission to get Gatorade from the store in the facility. RN #650 stated she and the resident had to purchase Gatorade in place of the Pedialyte. RN #650 stated Resident #226 had uncontrollable diarrhea from the treatment of cancer and that was why the Pedialyte was ordered. RN #650 stated they just now were able to get the diarrhea under control. RN #650 stated Resident #650 was alert and oriented and would ask for it, if he was not getting it. RN #650 stated she was not sure what the issue was, but when she had contacted the pharmacy, they had her call dietary. RN #650 stated management was aware. RN #650 stated she had given Resident #226 the oral solution sent up by dietary once today and that it was kept in the refrigerator, with his name on it, in the kitchenette across from the nursing station. Observation at this time of the refrigerator with RN #650 revealed nothing with the resident's name on it. RN #650 stated that she needed to get him more. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Follow-up interview on 06/17/24 at 3:27 P.M., with RN #650 revealed she had to go purchase the oral electrolytes (Powerade) with her own money for Resident #226 to take instead of the Pedialyte. Observation at this time revealed two unopened, 28 fluid ounce bottles of Powerade sitting at the nurses' station. RN #650 clarified the solution that was provided by dietary at times and purchased by her and the resident was Powerade, not Gatorade. RN #650 verified when she signed off on the MAR it was Powerade that was given except for the 2:00 P.M. administration, she had signed off on it but had not given it yet due to it not being available at that time. RN #650 stated she was in the process of giving the resident a large Styrofoam cup full of ice with the Powerade poured in. RN #650 stated she always administered the Powerade that way and was able to give two servings per bottle. RN #226 stated that one-time Licensed Practical Nurse (LPN) #651 had Door Dashed (food delivery company) Pedialyte for Resident #226. RN #650 stated dietary did not bring the Powerade consistently. Interview on 06/17/24 at 3:38 P.M. with LPN #651 verified she had Door Dashed Pedialyte for Resident #226. LPN #651 stated she was not going to sign off on orders that were not being provided. LPN #650 stated she was not sure what the issue was but knew the pharmacy did not carry Pedialyte. LPN #651 stated there should be a bottle of Pedialyte in the refrigerate with Resident #226 that she had brought in. Observation on 06/17/24 at 3:42 P.M. with LPN #651 revealed in the locked medication room, a small refrigerator, a bottle of Pedialyte that was three fourths full, with the resident's name written on the top of the cap. At this time, RN #651 stated she did not know that was in there. Interview on 06/17/24 at 3:47 P.M. with Pharmacy Director (PD) #605 revealed they did not normally stock nutritional products such as Pedialyte and that it would come from central supply. PD #605 stated it could be something she could order but it was not normally on her stock. Interview on 06/17/24 at 4:03 P.M. with Registered Dietitian (RD) #652 stated the dietary department only purchased food and beverages. RD #652 stated they did not purchase nutritional supplements such as Pedialyte. RD #652 stated the Pedialyte would come from central supply. RD #652 stated there was no Pedialyte in the facility at this time, and someone had to go out to get it. Interview on 06/17/24 at 4:29 P.M. with the Assistant Director of Nursing (ADON) #600 stated they had Pedialyte, and it was provided through central supply. ADON #600 stated she was not aware there were issues with the facility providing Pedialyte for Resident #226. ADON #600 stated she also was not aware that staff had been purchasing Powerade or had Door Dashed Pedialyte for the resident. ADON #600 stated she was aware of one time that they had ran out, but she had gotten an order over the phone from the physician to give Powerade instead until the Pedialyte was provided. ADON #600 stated they had attempted to get the order changed to Powerade, but Resident #226's oncologist wanted to keep the Pedialyte. ADON #600 stated the Pedialyte was kept in central supply on the bottom shelf and should be there. Observation on 06/17/24 at 4:41 P.M. of central supply revealed no observation of Pedialyte. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Interview on 06/18/24 at 10:03 A.M. with Central Supply Staff (CSS) #653 revealed he did the stock in central supply which included going to the nursing units to see what was needed. CSS #653 stated he would take pictures or nursing staff would like him to know what was needed to restock/stock on the nursing units. CSS #653 stated ordering of products went through someone else. CSS #653 stated Pedialyte was provided either through central supply or pharmacy, and that they had it consistently. CSS #653 stated there was only one resident that he was aware of that used Pedialyte, and that he was not aware that there was none on the nursing unit. CSS #653 was asked to provide evidence of invoices for the Pedialyte through central supply. Interview on 06/18/24 at 1:09 P.M. with Resident #226 stated sometimes he received Powerade instead of Pedialyte, and sometimes he received nothing at all. As of 06/18/24 at 4:15 P.M., the facility did not provide invoices or documented evidence of past purchases of Pedialyte. This deficiency represents non-compliance investigated under Complaint Numbers OH00154919 and OH00154420.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39973 Based on interview, observation, record review, review of manufacture guidelines, facility policy review, and review of the facility Caregiver Safety Tips for use of a mechanical lift (device used to move a resident from one place to another)/ sling revealed the facility failed to ensure Resident #280's mechanical lift sling was properly examined prior to transferring resulting in the sling strap breaking and Resident #280 falling to the floor. The facility also failed to complete a thorough nursing assessment prior to Resident #280 being transferred back to bed, the mechanical lift slings were properly laundered, and a thorough investigation was completed of the incident. This affected one resident (#280) of three residents reviewed for falls. The facility census was 285. Findings include: Review of the medical record for Resident #280 revealed an admitted [DATE] with diagnoses including dementia, hypertension, and hemiplegia affecting her right dominate side. Review of the care plan dated 08/23/21 revealed Resident #280 had an activities of daily living self - care deficit performance deficit. Interventions included the resident required assistance by staff to move between surfaces. Resident #280 was also at risk for falls and/ or injury. Interventions included anticipating safety needs and potential hazards. (There was nothing in the comprehensive care plan regarding to use mechanical lift for transfers per her physician order). Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #280 had impaired cognition. She was totally dependent on staff for transfers. Review of the June 2024 Physician Orders revealed Resident #280 had an order dated 05/30/24 that she was to be transferred with a two-person assist by use of a mechanical lift. Review of June 2024 Medication Administration Record (MAR) revealed on 06/12/24 at 6:11 P.M. Resident #280 had a pain that was assessed at a ten on a pain scale of zero to ten, ten being severe. She was administered acetaminophen 325 milligram (mg) (analgesic) two tablets by mouth for her pain that was documented as effective. Review of the unsigned Investigation Summary dated 06/12/24 revealed at approximately 5:00 P.M. Resident #280 was being transferred by two STNAs by use of a mechanical lift, and the strap on the mechanical lift sling broke resulting in the resident falling to the ground landing on her left side. The investigation revealed the mechanical lift sling was dated November 2023 and showed no signs of tearing, fraying, or weakening. The straps were checked post fall, and no other straps were noted to be frayed or with any sort of decline even after pulling on the straps. The investigation revealed staff followed the protocol of transferring with mechanical lift utilizing two staff transfer and the mechanical lift sling was inspected prior to use. The conclusion of the investigation was that the mechanical lift sling was inspected, dated within the year framework, and washed per facility procedure of hanging to dry and inspection post#641. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility incident report, Witnessed Fall dated 06/12/24 at 5:35 P.M. and completed by Licensed Practical Nurse (LPN) #642 revealed the nurse was alerted by the STNAs that they were using the mechanical lift to transfer the resident into bed, and the mechanical lift sling broke causing Resident #280 to fall to the floor. The report revealed vital signs were obtained and were stable, and range of motion was performed and was within normal limits to all extremities. The resident was assisted by multiple staff members to her bed. Resident #280 complained of leg pain at approximately 10:00 P.M. and she was administered Tylenol with good results. Review of the witness statement dated 06/12/24 and completed by Agency STNA #644 revealed at 5:35 P. M. Resident #280 was transferred with use of mechanical lift to her bed, and the mechanical lift sling strap broke on the left side while moving her to her bed. Agency STNA #644 revealed she notified the nurse regarding the fall, and Resident #280 did not hit her head. Review of the witness statement dated 06/12/24 and completed by STNA #641 revealed she assisted Agency STNA #644 in transferring Resident #280 to the bed by using a mechanical lift. While transferring Resident #280, one of the mechanical lift sling straps broke which resulted in Resident #280 falling. Review of the nursing note dated 06/12/24 at 5:40 P.M. and completed by LPN #642 revealed she was notified by the STNAs that Resident #280 fell from the mechanical lift when they were transferring her. The note revealed STNAs stated she did not hit her head but landed on her left side. Upon assessment, Resident #280 was able to move all extremities without any new discomfort. Resident #280 voiced pain in her left knee but also stated it was chronic. Primary Care Physician #647 was notified. Review of the nursing note dated 06/12/24 at 6:30 P.M. and completed by Registered Nurse (RN) Supervisor #643 revealed Resident #280 fell out of the mechanical lift while being transferred back into bed. The note revealed one of the straps on the mechanical lift sling broke resulting in the resident falling. One of the staff members who was in the room during the transfer stated she had fell on her left side but did not hit her head. During the assessment Resident #280 was able to move all extremities within her normal limits without any new discomfort. The note revealed she voiced pain to her left knee but stated it was chronic. Review of the nursing note dated 06/12/24 at 6:31 P.M. and completed by LPN #642 revealed Primary Care Physician #647 ordered an x-ray for Resident #280 and give Tylenol to relieve her pain. Interview on 06/13/24 at 3:12 P.M. with Resident #280's daughter revealed Resident #280 had a fall last evening, 06/12/24 as staff was transferring her from her chair to her bed by use of a mechanical lift. She revealed the facility told her the mechanical lift sling strap broke causing her to fall from mid-aid to the floor. She stated, I feel this is neglect; How can a resident that is totally dependent on staff in transferring fall from that high up in the air to the floor. She revealed the facility stated she was having pain and when she asked how much, they had stated it was a ten. She revealed she requested multiple x-rays be completed to make sure nothing was broken. Review of the x-ray report of the left knee-three view, left hip, and right femur dated 06/13/24 revealed Resident #280's x-rays were negative. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/17/24 at 8:59 A.M. with Housekeeping and Laundry Supervisor #640 revealed all mechanical lift slings were washed and then air dried to not destroy the texture of the sling. He showed a rack that all slings were to be hung on after they were washed to air dry. Interview and observation on 06/17/24 at 10:05 A.M. revealed Resident #280 was sitting up in her Broda chair with a mechanical lift sling underneath her. She was unable to provide any details regarding Resident #280's fall that occurred on 06/12/24. Interview on 06/17/24 at 11:06 A.M. and 3:33 P.M. with LPN #642 revealed Agency STNA #644 and STNA #641 were transferring Resident #280 with a mechanical lift when one of the straps on the sling broke causing Resident #280 to fall to the floor. She was not in the room when the incident happened and by the time she came to assess Resident #280, she was already in bed as Agency STNA #644 and STNA #641 assisted her back in bed. LPN #642 stated, yes I know they should not have gotten her up first without me assessing her. LPN #642 was not aware of any other nurse assessing Resident #280 prior to the staff transferring her back into bed as she was the one that obtained the vital signs and checked her range of motion when she was back in bed. LPN #642 revealed she was complaining of pain in her left thigh area where she had fallen. She saw the sling and revealed the strap had snapped into two pieces as it looked old and worn. Interview on 06/17/24 at 11:10 A.M. with RN Supervisor #643 revealed when she arrived at Resident #280's room, she was in bed. She verified she looked at the mechanical lift sling, and one of the lower straps had broken when the aides were transferring Resident #280 from her chair to bed causing her to fall to the floor. She revealed, it looked like it was frayed. Interview on 06/17/24 at 11:58 A.M. with the Director of Nursing (DON) revealed she was on vacation when the incident occurred with Resident #280 falling from the mechanical lift due to the strap on the sling breaking, and that [NAME] President of Clinical Services #632 completed the investigation. She verified that she had not seen the sling and that the facility no longer had the sling as it was discarded. She verified Resident #280's comprehensive care plan did not include that Resident #280 was to be transferred by use of a mechanical lift. She verified the nurse was to assess anyone after a fall before getting the resident off the floor and was not aware Resident #280 was not assessed prior to Agency STNA #644 and STNA #641 transferring her back into bed. She also verified STNA #641 had a competency completed on 03/15/24, and the competency form revealed nothing regarding the sling was to be examined for tears, holes, and frayed seems before lifting a resident. She revealed the facility followed Caregiver Safety Tips which revealed staff was to perform safety checks before lifting the patient by examining hooks and fasteners to ensure they would not unhook during use, double check position and check the stability of straps before lifting the patient. She also verified the procedure revealed to air dry the slings only, and do not machine dry. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/17/24 at 1:19 P.M. with [NAME] President of Clinical Services #632 revealed she completed the investigation regarding the incident with Resident #280's fall from the mechanical lift. She revealed she had only gone by the two witness statements, incident report, and documentation in the medical record but had not spoken with any staff involved in the incident including (nurses, STNAs, and/ or laundry personnel). She revealed she was not aware STNA #641 stated she, and Agency STNA #644 placed Resident #280 back in bed prior to a nurse assessing her, and that STNA #641 revealed she had not checked the sling including checking the strap prior to transferring Resident #280. She then revealed Assistant Director of Nursing (ADON)/ RN #600 had interviewed the staff involved in the incident. She revealed she had observed the sling and noted the lower middle strap on the right side had torn/ broke. Interview on 06/17/24 at 1:37 P.M. with ADON/ RN #600 revealed she had not completed the formal investigation regarding the incident with Resident #280's fall from the mechanical lift except for interviewing RN #645. She did not talk with any other staff involved in the incident. She revealed she was not aware that LPN #642 had stated the STNAs had assisted the resident back into bed before a nurse assessed her, and that STNA #641 did not check the sling prior to transferring the resident back to bed. She revealed she had not obtained a witness statement from RN #645 and verified the nursing notes and incident report did not include any assessment completed by RN #645 and that there was only documentation per RN Supervisor #643 and LPN #642 (after it was brought to the facility attention that LPN #642 stated the STNAs had transferred Resident #280 back to bed prior to a nurse assessing her. The facility stated RN #645 had assessed her). Interview on 06/17/24 at 2:10 P.M. with STNA #641 revealed she assisted in transferring Resident #280 with Agency STNA #644 from her Broda chair to the bed. She revealed while Resident #280 was in the air, at a height above her bed, the mechanical lift sling strap broke, and Resident #280 fell to the floor from the lift. She stated, we did not notice it was on the last few strings. STNA #641 revealed she did not look at the straps while hooking the sling onto the mechanical lift. STNA #641 verified she had not checked the integrity of the sling, including the strap, because she was already up in the chair. STNA #641 revealed Resident #280 was complaining of her leg hurting and that was why STNA #641 and Agency STNA #644 transferred her back into the bed before the nurse came to assess her. STNA #641 verified again that she had not checked the sling's integrity prior to transferring as STNA #641 stated, I would not check the sling again as they had already gotten her up with the sling, so they would have checked it when they got her up. Observation on 06/18/24 at 10:47 A.M. of laundry revealed Laundry #648 had taken a load out of the washer and was proceeding to place the laundry into the dryer including mechanical lift slings. He proceeded to push the top button on the dryer that indicated High Heat and walked away. Interview on 06/18/24 at 10:50 A.M. with Laundry #648 verified he had placed five mechanical lift slings into the dryer on high heat. Laundry #648 stated my mistake, yes they are not supposed to go in the drier. Laundry #648 then proceeded to grab all five slings bunched all together he placed the slings into a laundry cart and did not drape them individually on the previously designated laundry rack for drying. Re-interview on 06/18/24 at 11:27 A.M. with Housekeeping/ Laundry Supervisor #640 verified Laundry #648 should not have placed the mechanical lift slings in the drier on high heat and should have utilized the rack to air dry each sling individually. He stated Laundry #648 was new to the facility. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: King David Post Acute Nursing & Rehabilitation LLC		STREET ADDRESS, CITY, STATE, ZIP CODE: 27100 Cedar Rd Beachwood, OH 44122	

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/18/24 at 12:20 P.M. with RN #645 revealed she had received a call that Resident #280 had a fall in her room and was lying on her right side. She revealed she went into the room quickly and made sure she did not hit her head. She revealed Resident #280 had complained of left knee pain but the STNA's stated that she always complained of her knee hurting, so felt it was chronic. She verified she had not checked her medical record to see if she had any previous complaints of pain documented, she went by the STNAs stated at the time. She revealed Resident #280 was able to move all her extremities, and she left the room to go get the vital signs machine to check her vital signs. She revealed she did not communicate to the aides not to put her to bed as she thought she would just grab the vital signs machine outside of her room and notify LPN #642 (Resident #280's assigned nurse), but the machine was not there. She revealed by the time she returned, the aides had placed Resident #280 back into the bed, and LPN #642 proceeded to complete the rest of the assessment including vital signs. She verified she had not documented her partial assessment and that she had not completed a witness statement regarding the incident as she was just asked today, 06/18/24, to complete one. Review of the unlabeled mechanical lift competency, revealed STNA #641 had a competency completed on 03/15/24. The competency revealed nothing regarding ensuring the sling was examined for tears, holes, and frayed seems before lifting a resident. Review of undated Caregiver Safety Tips revealed staff was to examine the sling for tears, holes, and frayed seams and not use a sling if any signs of wear. The staff was to perform safety checks before lifting the patient by examining hooks and fasteners to ensure they would not unhook during use, double check position and stability of the straps before lifting the patient. The procedure revealed to air dry only, and do not machine dry. Review of the facility policy labeled, Lifting Machine, using a Mechanical, revised July 2017, the purpose of the procedure was to establish the general principles of safe lifting using mechanical lifting device. The policy revealed to ensure all necessary equipment including slings, hooks, straps were in good condition. The policy revealed before lifting a resident, double check the security of the sling attachment, examine all hooks clips and fasteners. The sling was to be washed and sanitized according to manufactures guidelines. Review of the facility policy labeled, Falls and Fall Risk, managing, dated March 2018, revealed there was nothing in the policy regarding assessing thoroughly a resident after a fall prior to staff getting resident up. Review of the manufacture guidelines labeled; User Instruction Manual Hoyer One Piece Sling, dated 2022, revealed to avoid injury read manual prior to use. The guideline revealed it is the responsibility of a competent person to conduct a thorough risk assessment prior to using any sling to ensure proper sling choice, method of positioning in the sling, and procedure for transfer has been correctly determined for the patient. The guidelines revealed that slings were checked each and every time prior to use to ensure the safety of the patient. Bleached, torn, cut, frayed or broken slings were unsafe and must be discarded and replaced. The guideline revealed a warning to check the sling and stitching before each use and broken slings could result in serious injury or death to the patient. The guideline revealed to cool dry tumble, air dry or dry at very low temperature. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the manufacture guidelines labeled; User- Service Manual Lifting and Repositioning Hoyer HPL402 Power Patient Lift, dated 2024, revealed torn, cut, frayed, or broken slings could fail resulting in serious injury or death to patient. The guideline revealed to use only slings in good condition. The lift maintenance checklist revealed to check slings and straps for wear and damage before each use. This deficiency represents non-compliance investigated under Complaint Numbers OH00154618 and OH00154331.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39973 Based on observation, interview, record review, and review of facility policy revealed the facility failed to ensure Resident #285's incontinence care was completed in a timely manner, did not place soiled linen and incontinence briefs (a product that holds urine or bowel movement) on the floor and that Resident #285 did not have two incontinence briefs applied at once. This affected one resident (#285) out of three residents reviewed for incontinence care. This had the potential to affect 50 residents (#20, #23, #26, #37, #38, #47, #48, #57, #60, #67, #72, #89, #91, #95, #119, #133, #135, #136 #138, #143, #150, #151, #155, #160, #169, #171, #189, #193, #195, #210, #213, #216, #217, #219, #221, #222, #233, #238, #246, #247, #248, #254, #257, #264, #274, #275, #278, #280, #282, and #285) on the Fairmount Unit that were identified as incontinent. The facility census was 285. Findings include: Review of the medical record for Resident #285 revealed an admitted [DATE] with and her diagnoses including Parkinson's disease, diabetes, morbid obesity, urinary incontinence, and heart failure. Review of the care plan dated 06/19/19 revealed Resident #285 had bowel and bladder incontinence related to dementia and immobility. Interventions included checking the resident every two hours and assisting with toileting as needed, providing peri care after each incontinent episode, and checking skin integrity daily. There was nothing in the comprehensive care plan that Resident #285 was to wear two incontinence briefs at once. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #285 had impaired cognition. She was dependent on staff assistance with toileting and hygiene and required maximum assistance of staff with rolling left and right. She was always incontinent of bowel and bladder. Interview on 06/12/24 at 10:45 A.M. with Resident #285 revealed she was cognitively impaired as well as spoke a different language and was unable to be interviewed in regard to details regarding her incontinence care. Interview on 06/12/24 at 10:55 A.M. with State tested Nursing Assistant (STNA) #623 revealed she was assigned to care for Resident #285, and she started her shift on 06/12/24 at 7:00 A.M. She revealed that this was the first time she was providing Resident #285's care as she was still on her first set of rounds. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 06/12/24 at 10:55 A.M. of incontinence care provided by STNA #622 and STNA #623 revealed Resident #285 had two incontinent briefs on. STNA #623 verified the resident had two incontinent briefs on and she did not know why as she should only have one in place. She verified the first incontinent brief was saturated in urine and that the second incontinent brief was also wet from urine. She verified from at least from 7:00 A.M. to 10:55 A.M. (almost four hours) Resident #285 was not provided incontinence care, and incontinence care should be provided every two hours. STNA #623 verified Resident #284 had urinated multiple times by the looks of both incontinence products. STNA #623 revealed that she had been unable to provide timely incontinence care as there was too many other residents that required the time, including getting residents up for therapy, residents up for dialysis, and showers that were scheduled, causing residents, including Resident #285, to not receive the timely care. STNA #623 stated she was busy caring for other residents. Interview on 06/12/24 at 11:10 A.M. with Assistant Director of Nursing (ADON)/ Registered Nurse (RN) #600 verified residents should not have two incontinence briefs in place at once, and incontinence care was to be provided every two hours. She revealed she was unsure of the reason for the delay in care as there was no excuse as the unit had six aides. Observation on 06/13/24 at 2:39 P.M. revealed Resident #285 rang her call light, and Licensed Practical Nurse (LPN) #900 answered her call light. Resident #285 requested to be changed. Observation on 06/13/24 at 2:44 P.M. revealed STNA #637 gathered the supplies to complete incontinence care and then STNA #638 came into the room to provide the incontinence care at 2:47 P.M. STNA #637 exited the room. STNA #638 proceeded to pull down the sheets, and Resident #285 had two incontinent briefs in place. STNA #638 stated that she had not changed her previously as every time she had entered the room Resident #285 stated she did not need changed. STNA #638 stated she had offered incontinence care at 8:15 A.M., 10:00 A.M., and now. This was the third time she had been in the room. STNA #638 revealed she did not know who had double briefed the resident as she had not. She stated it was most likely it was night shift, because Resident #285 had not been changed since day shift arrived. She stated, majority of people double brief. STNA #638 provided incontinence care and Resident #285 appeared to be slightly wet. During the incontinence care, Resident #285 had a large bowel movement and was provided incontinence care. STNA #638 proceeded to throw both incontinence briefs, three towels, three washcloths, and the washable incontinence pad on the floor. STNA #638 verified she placed the above items on the floor and stated she would get a bag. Interview on 06/13/24 at 3:09 P.M. with Unit Manager/ Licensed Practical Nurse (LPN) #616 as she was in the hallway revealed she knew night shift did not apply two disposable incontinent briefs as she heard about the incident that had occurred on 06/12/24 and checked Resident #285 to ensure she did not have two incontinent briefs on as well as checked to ensure she was changed timely. Unit Manager/LPN #616 entered Resident #285's room and verified that the soiled linen continued to remain on the floor, including the two disposable incontinence briefs. Unit Manager/LPN #616 began to question STNA #638 how Resident #285 had two incontinence products on as she had checked Resident #285 after third shift left and that she did not have two incontinence briefs on. Unit Manager/LPN #616 stated that STNA #638 was the aide assigned to her Resident #285 throughout the day. STNA #638 continued to deny applying two incontinence briefs. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy labeled, Perineal Care, last revised February 2018, revealed the purpose of the policy was to provide cleanliness and comfort to the resident, to prevent infections, and to observe the resident's skin condition. The policy revealed if the resident refused the procedure the reason why and interventions taken was to be documented. There was nothing in the policy in regard to providing incontinence care every two hours and/ or as needed and/ or anything in regard to not applying two briefs at once. This deficiency represents non-compliance investigated under Complaint Numbers OH00154919, OH00154865, OH00154318, and OH00153888.

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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.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 39973

Based on observation, interview, record review, and review of facility policy the facility failed to ensure oxygen cylinders was secured safely and failed to ensure residents had oxygen signs indicating oxygen was in use upon entrance to their rooms. This affected three residents (#51, #193, and #262) out of four residents reviewed for oxygen use. This had the potential to affect 38 residents (#1, #6, #10, #17, #19, #25, #35, #38, #44, #71, #83, #99, #105, #115, #117, #130, #140, #148, #150, #155, #193, #194, #195, #199, #200, #205, #210, #211, #213, #219, #225, #241, #242, #243, #258, #261, #262, and #283) with orders for oxygen. The facility census was 285.

Findings include:

1. Review of the medical record for Resident #51 revealed an admitted [DATE] with diagnoses including chronic respiratory failure, hypertension, and diabetes.

Review of the care plan dated 04/02/24 revealed Resident #51 was on a respiratory program including cough and deep breathing per protocol. Interventions included assess respiratory status, cough and deep breathing exercises, and medications as ordered. There was nothing in her care plan regarding oxygen use.

Review of June 2024 physician orders revealed Resident #51 was to have oxygen per nasal cannula as needed if oxygen saturation rate was less than 92 percent or if having shortness of breath.

Observation on 06/17/24 at 8:40 A.M. revealed there was one green E-cylinder (a cylinder containing oxygen that was combustible) free standing on the floor in her room not in a oxygen rack or holder. Also, on observation, there was not a sign on the outside of Resident #51's room indicating oxygen was in use.

Interview on 06/17/24 at 8:46 A.M. with Unit Manager/ Licensed Practical Nurse (LPN) #901 verified in Resident #51's room contained one e-cylinder freestanding not in a proper oxygen holder/ rack, and there was no sign upon entrance to her room regarding oxygen in use.

2. Review of the medical record for Resident #193 revealed an admitted [DATE] with diagnoses including pneumonia, asthma, and hypertension.

Review of the care plan dated 04/19/21 revealed Resident #193 had the potential for altered respiratory status and difficulty breathing related to asthma. Interventions included administering medications as ordered, elevate head of bed, and monitor symptoms of respiratory distress. There was nothing in the care plan regarding oxygen use.

Review of June 2024 physician ordered revealed Resident #193 had an oxygen order for two liters via nasal cannula continuous to maintain oxygen saturation rate above 93 percent due to pneumonia and asthma.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and observation on 06/17/24 at 8:23 A.M. revealed Resident #193 was lying in bed and had oxygen in place per nasal cannula. She had one e-cylinder tank free standing next to her bed as well as no sign upon entrance to her room regarding oxygen in use. Interview on 06/17/24 at 8:35 A.M. with Unit Manager/ LPN #616 verified Resident #193 had one e-cylinder free standing not in a proper holder or rack next to her bed, and there was not an oxygen in use sign upon entrance to her room. 3. Review of the medical record for Resident #262 revealed an admitted [DATE] with diagnoses including acute and chronic congestive heart failure, acute and chronic respiratory failure with hypoxia, and diabetes. Review of the care plan dated 03/07/24 revealed Resident #262 had oxygen due to acute and chronic respiratory failure with hypoxia and chronic obstructive pulmonary disease (COPD). Interventions included oxygen as ordered and monitor for difficulty breathing. Review of the June 2024 Physician Orders revealed Resident #262 had an oxygen order for 1.5 liters per nasal cannula continuous. Observation on 06/17/24 at 8:38 A.M. revealed Resident #262 had oxygen per nasal cannula as ordered, and there was no sign indicating oxygen was in use upon entrance to his room. Interview on 06/17/24 at 8:46 A.M. with Unit Manager/ LPN #901 verified Resident #262 was on oxygen and did not have a sign upon entrance to her room regarding oxygen in use. Review of the facility policy labeled; Oxygen Administration, last revised October 2010, revealed the purpose of the procedure was to provide guidelines for safe oxygen administration. The policy revealed Oxygen in use signs would be on the outside of the room entrance door. There was nothing in the policy regarding ensuring e-cylinders were not left free standing and were in a proper holder/ rack to prevent tipping. This deficiency substantiates Complaint Number OH00154865.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39973 Based on observation, interview, record review, review of facility policy and clinical pharmacology guidelines and manufacture insulin pen guidelines, the facility failed to ensure Resident #264's insulin by route of insulin pen (an injection device that can use to deliver a preloaded insulin subcutaneously (under the skin)) was administered in a safe manner according to the guidelines. This affected one resident (#264) out of three residents observed for insulin administration. This had the potential to affect 47 Residents (#4, #5, #14, #17, #34, #55, #57, #65, #66, #68, #75, #87, #89, #91, #93, #101, #102, #107, #117, #122, #123, #128, #136, #138, #144, #147, #156, #160, #177, #183, #187, #188, #189, #203, #206, #212, #224, #228, #234, #253, #255, #264, #274, #277, #279, #284, and #285) that had physician orders for insulin. The facility census was 285. Findings include: Review of the medical record for Resident #264 revealed an admitted [DATE] with diagnoses including hypertension, seizures, diabetes, and long-term use of insulin. Review of the care plan dated 11/25/22 revealed Resident #264 had diabetes mellitus. Interventions included administering diabetic medications as ordered, monitoring for signs of hypoglycemia and hyperglycemia symptoms, and monitoring blood sugars as ordered. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #264 had intact cognition and she received seven days of insulin during the seven-day assessment period. Review of the June 2024 physician orders revealed Resident #264 had an order for Humalog solution 100 units per milliliter (ml) inject per sliding scale subcutaneously before meals due to diabetes. The sliding scale indicated to administer six units if her blood glucose level was 251 to 300. Observation on 06/11/24 at 11:33 A.M. revealed Licensed Practical Nurse (LPN) #604 obtained Resident #264's blood glucose level and it was 256. She retrieved a new insulin Humalog flex pen and instead of placing a specifically designed needle for the insulin pen on the end, LPN #604 used an insulin needle to aspirate the six units into the insulin needle. LPN #604 administered to Resident #264's left upper arm with the insulin syringe. Interview on 06/11/24 at 11:47 A.M. with LPN #604 verified she had specifically designed needles for the insulin pen on her medication cart but that she preferred to draw the insulin out of the insulin pen with a regular insulin needle. LPN #604 revealed when she used the insulin pen, she was unable to see the exact amount a resident would get and did not trust the insulin pen delivery system. LPN #604 verified she had not discussed her concerns regarding the insulin pen with pharmacy and/ or nursing management. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Interview on 06/11/24 at 12:28 A.M. with the Director of Pharmacy #605 (the facility had their own onsite pharmacy) revealed they went by the Clinical Pharmacology Guidelines as well as the manufacturer guidelines regarding the procedure a medication was to be administered. She reviewed both guidelines and revealed there was nothing in the guidelines that stated a nurse could take an insulin needle and aspirate the insulin out of the end of an insulin pen. She revealed the guidelines only gave instructions to apply the specifically designed needle to the end of the pen and administer in that manner. She verified there was nothing indicating a procedure a nurse should follow to administer insulin using a regular insulin syringe. She revealed she was unsure why a nurse would not just utilize the needle that was designed to go on the insulin pen and administer according to the guidelines. She verified that she cannot say a nurse can do it that way since not in the guidelines. She revealed no nurses have ever brought to her attention concerns regarding the accuracy of the insulin pen delivery system. Interview on 06/12/24 at 1:07 P.M. with President and Chief Operating Officer #601 and [NAME] President of Clinical Service #632 revealed they were not aware of any concerns from a nurse with the insulin pen delivery system and using a regular insulin syringe to draw out insulin instead of a utilizing the designed pen needle. They did not have a policy and/ or procedure that permitted a nurse to do this and verified the manufacture guidelines also did not have that this was permitted. Review of the undated Clinical Pharmacology revealed administration information for Humalog insulin pen revealed instructions for applying standard pen needles and safety pen needles. The administration information revealed the needle should remain in the skin for at least six seconds to ensure complete delivery of the insulin dose, dial doses on the insulin pen in one-unit increments. There was nothing in the guidelines regarding taking a regular insulin needle and aspirating insulin from the end of the insulin pen. Review of the Instructions for Use Humalog Kwik Pen, dated 2007, revealed instructions for preparing the pen for administration of the insulin included: pull the pen cap straight off, wipe the rubber stopper with alcohol, select a needle and pull the paper tab from the outer needle shield, push the capped needle straight onto the pen and twist the needle on until it is tight, prime the pen by turning the dose knob to select two units, hold the pen with the needle pointing up and push the dose knob until it stopped and a zero was seen, select the dose ordered for the patient by turning the knob to the selected units needed, insert the needle into the skin, push down on the dose knob and slowly count to five before removing the needle. There was nothing in the manufacture's guidelines and/ or instructions on using a regular insulin needle and aspirating insulin from the end of the pen. Review of the facility policy labeled; Subcutaneous Injections, dated March 2011, revealed guidelines for the administration of medication by subcutaneous injection. There was nothing in the policy regarding the administration of insulin by use of an insulin pen. Review of the facility policy labeled; Administering Medications, dated April 2019, revealed repackaging single use vials required compliance standards. If there was a need to repackage unopened vials the consultant pharmacist was contacted. The policy revealed insulin pens containing multiple doses of insulin were for a single resident use only and changing the needle does not make it safe to use insulin pens for more than one resident. There was nothing in the policy regarding using a regular insulin needle to aspirate the insulin from the end of an insulin pen. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
King David Post Acute Nursing & Rehabilitation LLC	27100 Cedar Rd Beachwood, OH 44122

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	This deficiency substantiates Master Complaint Number OH00154920 and Complaint Numbers OH00154919, OH00154481, and OH00154304.