STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365094	A. Building B. Wing	08/20/2024

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37096 Based on observation, interview, record review, and facility policy review the facility failed to ensure staff treated Residents #68 and #126 with respect and dignity. This affected two residents (#68 and #24) of ten residents reviewed for dignity and respect. The facility census was 276. Findings include: 1. Review of Resident #68's medical record revealed an admitted [DATE] with diagnoses including multiple sclerosis, suprapubic cystostomy, a surgical connection between the bladder and abdomen to drain urine, Crohn's disease, malnutrition, Parkinson Disease, fracture of the right patella, (the knee bone) and tibia (shin bone), and neuromuscular bladder, disfunction of the bladder due to nerve injury. Review of Resident #68's comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed he was cognitively intact and dependent on staff for eating, toileting, bathing, and personal hygiene. Review of Resident #68's care plan dated 07/02/24 revealed the resident had impaired functional abilities related to current medical diagnosis. Interventions included staff to assist with activities of daily living to promote independence, and staff to encourage use of assistive devices as needed. Interview on 08/12/23 at 10:50 A.M. with Resident #68 revealed he was not feeling well last night and had vomited about 2:00 A.M. The state tested nurse aide (STNA) cleaned him up but did not replace his blanket with a clean one. Resident #68 stated he wanted a clean blanket. Observation at this time revealed several large stains of dried substance on his blanket. Interview on 08/12/23 at 10:58 A.M. with STNA #433 verified Resident #68 needed a clean blanket. STNA #433 stated her sift started at 7:00 A.M., and she had not provided care to Resident #68. She stated she checked in on the resident earlier on her shift, and the resident requested the nurse. STNA #433 stated she would provide care to Resident #68 and get him a clean blanket. 2. Review of Resident #24's medical record revealed an admitted [DATE] with diagnoses including chronic osteomyelitis, pain, depression, chronic kidney failure, neoplasm of the prostate. (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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #24's quarterly MDS 3.0 assessment dated [DATE] revealed the resident was cognately intact and required supervision or touching assistance with eating. Review of the care plan dated 07/09/24 revealed Resident #24 had a self-care deficit and required staff for assistance for eating. Observation on 08/13/24 at 12:05 P.M. of the lunch time tray delivery revealed STNA #434 walked into Resident #24's room to deliver the tray. Resident's #24's daughter asked STNA #434 to set up the tray and remove the plastic wrapper from the ice cream container. STNA #434 stated she was not able to do that because of her fingernails and handed the lunch tray to Resident #24's daughter and walked out of the room. Interview at this time, with Resident #24's daughter stated the STNAs expect me to do their job when I am here at the facility. Resident #24's daughter had difficulty removing the plastic wrap and wanted STNA #434 to complete the task. Interview on 08/13/24 at 12:25 P.M. with STNA #434 stated Resident #24's daughter took the tray, and she assumed the daughter would take care of it. STNA #434 stated, normally, she would ask another staff to remove the wrapping on the ice cream. Interview with LPN #408 on 08/13/24 at 12:30 P.M. stated she would expect the STNA to get another staff member to remove the plastic and not expect the family to it. Review of the undated facility policy labeled, Resident Right stated employees shall treat all resident with kindness, respect, and dignity. This deficiency represents non-compliance investigated under Master Complaint Number OH00156678 and Complaint Number OH00156022.

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37097 Based on interview and record review the facility failed to notify Resident #281 or the resident's representative before a transfer to another room. This affected one resident (#281) of three residents reviewed for room changes. The facility census was 276. Findings include: Review of the closed medical record for Resident #281 revealed an admitted [DATE]. Diagnoses included multiple fractures of the pelvis, difficulty walking, muscle wasting and atrophy, diabetes, and cognitive communication deficit. The resident was discharged to an assisted living facility on 05/28/24. Review of the discharge Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #281 had impaired cognition. Review of the medical record revealed Resident #281 was transferred from Heights Pavilion Second Floor H133 to Heights Pavilion Second Floor H230 as of 05/15/24. (The resident's room was changed after dinner on 05/14/24). Review of the communication with family/power of attorney (POA) note on 05/15/24 at 9:21 A.M. revealed the Assistant Director of Nursing (ADON) #405 spoke with the daughter of Resident #281. The conversation included readdressing the move of the resident from one unit to another. (This communication note was not part of the resident's medical record. The other two residents reviewed for room changes had documentation of notification in the medical record prior to the room change). Review of the communication with family on 05/15/24 at 9:21 A.M. was the only documentation regarding Resident #281's transfer. There was no documentation prior to the move. Interview on 08/14/24 at 3:30 P.M. with ADON #405 verified there was no documentation in the medical record indicating Resident #281 and/ or the resident's representative were informed of the room change prior to the transfer. The resident's room was changed on 05/14/24 after dinner. This deficiency represents non-compliance investigated under Complaint Number OH00156022.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37096 Based on record review, interview, and observation the facility failed to provide wound care according to physician's orders for Resident #68. This affected one resident (#68) of three residents reviewed for wound management. The facility census was 276. Finding include: Review of Resident #68's medical record revealed an admitted [DATE] with diagnoses including multiple sclerosis, suprapubic cystostomy, a surgical connection between the bladder and abdomen to drain urine, Crohn's disease, malnutrition, Parkinson disease, fracture of the right patella (the knee bone) and tibia (shin bone), and neuromuscular bladder, disfunction of the bladder due to nerve injury. Review of Resident #68's comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed he was cognitively intact and had two stage IV pressure ulcers. (Full thickness tissue loss with exposed bone, tendon or muscle. Slough may be present on some parts of the wound bed. Often include undermining and tunneling). Review of Resident #68's care plan dated 07/02/24 revealed the resident had a right hip stage IV pressure ulcer and a coccyx stage IV pressure ulcer. Interventions include to perform wound treatments as ordered and continue with preventative care plan measures to prevent further skin breakdown. The care plan was updated on 08/12/24 stating the resident was non-compliant with dressing changes. Review of the August 2024 physician's orders revealed the wound treatment to coccyx stated to clean the wound with normal saline and pat dry and apply Anasept (a broad-spectrum antimicrobial cleaner), collagen for wound healing, calcium alginate (highly absorbent dressing), and cover with a silicone border dressing every other day. There was an order for wound treatment to the right hip to clean the wound with normal saline, pat dry apply Anasept, collagen, calcium alginate, and cover with a silicone border dressing every other day. Review of the August 2024 Treatment Administration Record (TAR) revealed the wound treatment for the right hip and coccyx for 08/10/24 were not signed off as completed. Interview on 08/12/23 at 10:50 A.M. with Resident #68 revealed his wound treatments were not completed on 08/10/23. Resident #68 stated he did not refuse the wound treatment. Observation on 08/12/23 at 10:58 A.M. with Licensed Practical Nurse (LPN) #418, the Unit Manager, of Resident #68's wound dressing for the right hip and the coccyx revealed the dressings were dated 08/08/24. Interview at this time with LPN #418 verified the wound dressing were dated as completed on 08/08/24, and he would have to investigate why the dressing was not signed off. LPN #418 provided wound care to Resident #68's right hip and coccyx. Review of the progress note dated 08/10/24 at 12:05 P.M. created on 08/12/24 at 12:17 P.M. stated the resident refused treatment and was educated on risks and benefits of completing treatment. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the August 2024 TAR revealed the right hip wound treatment, and the coccyx wound treatment dated 08/10/24 were signed off with a number two, indicating the resident refused treatment. Further interview on 08/12/23 at 12:30 P.M. with the LPN #418 stated after his investigation the nurse stated the resident refused the treatment and he had the nurse sign off the TAR and create a late-entry progress note. This deficiency represents non-compliance investigated under Complaint Number OH00156357.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** 37096 Based on observation, record review, interview, and facility policy review the facility failed to provide routine indwelling urinary catheter care and failed to have indwelling urinary catheter care orders in place for Resident #68. This affected one resident (#68) of three residents reviewed for indwelling urinary catheters. The facility census was 276. Findings include: Review of Resident #68's medical record revealed an admitted [DATE] with diagnoses including multiple sclerosis, suprapubic cystostomy, a surgical connection between the bladder and abdomen to drain urine, Crohn's disease, malnutrition, Parkinson's disease, fracture of the right patella (the knee bone) and tibia (shin bone), and neuromuscular bladder, and dysfunction of the bladder due to nerve injury. Review of the physician's orders revealed an order dated 06/21/24 to record output from the suprapubic catheter every shift. This order was discontinued on 07/30/24. An order dated 06/22/24 stated to change and date the indwelling urinary drainage bag. This order was discontinued on 07/30/24. An order dated 07/05/24 stated to change the suprapubic catheter on the fifth day of every month. This order wad discontinued on 08/05/24. An order dated 08/02/24 stated to cleanse the suprapubic catheter and apply a drain sponge daily. This order was discontinued on 08/08/24. An order on 08/08/24 to start treatment to cleanse the suprapubic catheter and change the drainage sponge three times a week on day shift. There were no orders to cleanse the suprapubic catheter from 06/21/24 through 08/01/24. There were no current orders to change out the urinary drainage bag, change the suprapubic catheter, or to empty the urinary drainage bag. There were no orders to monitor for signs and symptoms of urinary tract infections. Review of Resident #68's comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed he was cognitively intact and was dependent on staff for toileting. The assessment indicated the resident had an indwelling urinary catheter. Review of Resident #68s care plan dated 07/03/24 revealed the resident had a suprapubic catheter. Interventions included monitor and document intake and output as per facility policy, monitor and document for signs and symptoms of urinary tract infection such as pain, blood-tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temperature, foul smelling urine, altered mental status, change in behavior, and change in eating patterns. In addition, check tubing for kinks each shift, position the catheter bag and tubing below the level of the bladder, and maintain enhanced barrier precautions (EBP) while performing high-contact resident care activities. Review of Resident #68's physician's orders dated 08/02/24 stated to start Keflex 500 milligram (mg), an antibiotic, for seven days. Review of the urinalysis collected on 07/31/24 and reported on 08/04/24 resulted in a positive organism greater than 100,000 for Proteus mirabilis (bacteria) and greater than 100,000 Citrobacter freundii (bacteria). (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 08/12/24 at 10:50 A.M. Resident #68 revealed his urinary drainage bag was full. Interview at this time with Resident #68 revealed night shift did not empty his urinary drainage bag, and the state tested nurse aide (STNA) had not provided any care this morning. Interview on 08/12/24 at 10:58 A.M. with STNA #433 stated she started her shift at 7:00 A.M. and had not provided care to Resident #68. She stated she checked in on the resident earlier in her shift, and the resident requested the nurse. STNA #433 verified the urinary drainage bag was filled with urine and needed to be drained. STNA #433 was worried she would have to take the blame for night shift not emptying the resident's urine bag. Interview on 08/19/24 at 10:14 A.M. with Licensed Practical Nurse (LPN) #416, the Unit Manager, stated the process is on admission was to input indwelling urinary catheter orders for cleaning, changing the urine bag, and changing out the catheter. LPN # 416 verified that there were missing indwelling urinary catheter orders, and Resident #68 had a urinary tract infection. LPN #416 stated he was new to the position and did not input the indwelling urinary catheter orders. LPN #416 continued imputing missing orders as they were discovered. Review of the facility policy, Catheter Care, Urinary, revised August 2022, revealed the policy was to prevent urinary catheter-associated complications, including urinary tract infections. Documentation should include the following, date and time care was given, the name of the individual providing care, character of urine, and any problems noted during care. This deficiency represents non-compliance investigated under Master Complaint Number OH00156678.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37096 Based on record review, interview, and facility policy review the facility failed prevent a significant medication error when Resident #38, who was being treated for chronic pain, did not receive pain medication as ordered by the physician. This affected one resident (#38) of four residents reviewed for medication administration. The facility census was 276. Findings include: Review of Resident #38's medical record revealed an admitted [DATE] with diagnoses including multiple myeloma, anxiety, dementia, type II diabetes, and depression. The record revealed the resident was receiving hospice services. Review of the facility's pain documentation tab revealed the following: On 06/01/24, Resident #38 had a pain score of zero, on a scale of zero to ten, indicating no pain. On 06/20/24, Resident #38 had a pain score of one, indicating mild pain. On 07/01/24, Resident #38 had a pain score of zero, indicating no pain. There was no documented evidence of pain monitoring for Resident #38 from 07/01/24 through 08/15/24. Review of Resident #38's quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident was severely cognately impaired, had disorganized thinking, and had inattention. The assessment indicated the resident received scheduled pain medication. Review of Resident #38s care plan dated 06/24/24 revealed the resident had chronic pain related to comorbidities. Interventions included to evaluate effectiveness of pain-relieving interventions and monitor for resident's pain related to dietary intake. Review of the physicians' orders revealed an order dated 07/10/24 for a Fentanyl patch 12 microgram (mcg) (opioid pain medication), used to treat moderate to severe chronic pain, to be changed every three days for a diagnosis of multiple myeloma. Review of the Medication Administration Record (MAR) for July 2024 revealed the Fentanyl patch was administered on 07/13/24, unavailable on 07/16/24, and signed as administered 07/19/24. Review of the progress noted dated 07/19/24 at 7:06 P.M. revealed Resident #38 needed Fentanyl patches. A new prescription was to be sent to the pharmacy. The hospice nurse was aware. Review of the facility's-controlled drug record revealed the Fentanyl patch was signed out and administered 07/13/24 and 07/22/24. There was no documented evidence Resident #38 received the Fentanyl patch on 07/16/24 or 07/19/24. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with on 08/14/24 with the Hospice Case Manager #439 stated a new prescription for Fentanyl patches was submitted to the pharmacy on 07/10/24, and a new prescription was not needed on 07/19/24. Interview on 08/14/24 at 3:30 P.M. with the Director of Nursing (DON) revealed the facility charts by exemption and pain monitoring was to be documented in the progress notes. The physician conducts pain assessments. The DON stated Resident #38 did not exhibit any pain. Interview on 08/15/24 at 9:30 P.M. Registered Nurse (RN) #407, the Quality Assurance Nurse, revealed on 07/10/24 a prescription was sent to the pharmacy and was canceled on 07/11/24. Resident #38 did not receive the patch on 07/16/23 and 07/19/24 because a new prescription needed to be submitted. RN #407 stated the nurse signed off the medication on the MAR by mistake on 07/19/24 and put a progress note stating a new prescription was needed. Interview on 08/15/24 at 11:00 A.M. with Pharmacist (RPH) #430 revealed the facility receives orders through Point Click Care (electronic medical record) that flow to their pharmacy system. The two systems do not communicate well, and the prescription got canceled. Review of the undated facility policy labeled, King [NAME] Post Acute Care revealed the facility shall provide adequate management of pain to ensure that residents attain or maintain the highest practicable physical, mental, and psychosocial well-being. This deficiency represents non-compliance investigated under Complaint Numbers OH00156630, OH00156259, OH00156063, OH00156037, and OH00156022.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37096 Based on observation, record review, interview, and facility policy review the facility failed to ensure medications were always secure form unauthorized access. This affected one resident (#162) of 29 residents identified to receive medications on the involved nurse's assignment. The facility census was 276. Findings include: Review of the medical record for Resident #162 revealed an admitted [DATE] with diagnoses including hypertension, heart failure, vertigo, anxiety, syncope, seizures, and depression. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #162 had intact cognition and received and antibiotics and an opioid. Review of the physicians' orders for August 2024 revealed afternoon medication orders for Depakote 250 milligrams (mg) (anti-seizure medication) for seizures, Tramadol 50 mg (opioid pain medication), Tylenol 1000 mg (analgesic), gabapentin 10 mg (anticonvulsant and nerve pain medication), and a probiotic capsule (supplement). Observation on 08/07/24 at 11:34 A.M. revealed there was a medication cup sitting on Resident #162's nightstand. The medication cup contained six pills. Interview with Resident #162 at the time of the observation revealed the nurse left her afternoon pills on the nightstand to take at her convenience. Interview on 08/07/24 at 12:06 P.M. with Registered Nurse (RN) #406, the Unit Manager, verified there was a medication cup with six pills sitting on the Resident #162's nightstand and stated the Resident #162 does not self-administer her medications. Interview on 08/07/24 at 12:19 P.M. with Licensed Practical Nurse (LPN) #432 stated at 11:00 A.M. the resident was complaining about her shoulder pain and requested her afternoon medications. LPN #432 verified that she prepared Resident #162's afternoon medications and left them on the bedside table for Resident #162 to take with her lunch. LPN #432 stated the facility's policy was not to leave medications at the bedside. Review of the facility policy labeled, Administering Medications, dated April 2019, stated residents may self-administer their own medications only if the attending physician, in conjunction with the interdisciplinary care planning team, has determined that they have the decision-making capacity to do so safely. This deficiency is an incidental finding identified during the complaint investigation.