

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 09/12/2024
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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>30809</p> <p>Based on observation, resident interview, staff interview, and review of the employee handbook, the facility failed to ensure staff did have personal conversations, which included yelling into their phones, in resident rooms. not talk on their phone in resident care areas of the facility. This affected one (#294) out of four residents observed for staff -to-resident interactions. The facility census was 288.</p> <p>Findings include:</p> <p>An observation on 09/09/24 at 3:50 P.M. revealed Licensed Practical Nurse (LPN) #301 entered Resident #294's room to check on him and provide care as needed. LPN #301 was standing next to Resident #294's bed yelling in a very loud voice while talking on her personal cellular phone. After a few minutes LPN #301 exited Resident #294's room without speaking to Resident #294. LPN #301 continued to talk/yell loudly on her phone directly outside of Resident #294's room for a few more minutes.</p> <p>An interview with Resident #294 on 09/09/24 at 4:05 P.M. revealed he was startled by the way LPN #301 was yelling on the phone and wasn't sure why she was upset. Resident #294 stated he didn't like the staff talking on their cellular phone while in his room.</p> <p>An interview with LPN #301 on 09/09/24 at the time of the observation revealed she was talking to her children on the phone and they were locked out of their home. LPN #301 stated she was upset her children were unable to unlock the door to their home and needed to contact the landlord to assist them to gain entrance to their home.</p> <p>An interview with Chief Executive Officer (CEO) #302 on 09/10/24 at 2:12 P.M. revealed the staff had received clear direction of the use of their personal cellular phone in the resident care areas of the facility. CEO #302 stated she had talked to LPN #301 regarding the incident and verified the above findings.</p> <p>Review of the employee handbook employees received during orientation to the facility included item Number 46 which stated: Receiving or making personal calls while on duty. Only emergency calls are permitted when screened through a supervisor. Telephones on units may not be used by personnel, except with prior permission of your supervisor, for a specific call. Using a resident's or client's phone to make or receive personal calls for any reason at any time.</p> <p>(continued on next page)</p>

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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>This non-compliance was discovered during the complaint investigation.</p>

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30809</p> <p>Based on medical record review, observation and staff interview, the facility failed to maintain wheelchairs and durable medical equipment in a clean and sanitary manner one (#120) out of three residents who used a wheelchair for mobility. The facility census was 288.</p> <p>Findings include:</p> <p>Review of the medical record revealed Resident #120 was admitted on [DATE] and readmitted on [DATE]. Diagnoses included traumatic brain injury, cerebral infarction (stroke) with right sided hemiplegia and hemiparesis, cognitive communication deficit with dementia, brain cancer, hydrocephalus with cerebrospinal fluid drainage device, seizures, congestive heart failure, depression, hypothyroidism, and pulmonary eosinophilia.</p> <p>An observation on 09/12/24 at 7:45 A.M. revealed Resident #120 was assisted up to his wheelchair by State tested Nursing Assistant (STNA) #303. Resident #120's wheelchair had dried liquid substances and dried food/debris coating both the lower foot rest and leg rests of the wheelchair. STNA #120 applied both of Resident #120's lower leg ankle foot orthosis (AFOs) which had a coating of dried liquid/food substances and debris coating the surface of both AFOs. At the time of the observation STNA #303 verified the above finding.</p> <p>An interview with Licensed Practical Nurse (LPN) #304 on 09/12/24 at 7:51 A.M. revealed the STNAs were responsible for cleaning the residents' wheelchairs and other equipment during the night shift hours from 7:00 P.M. to 7:00 A.M. on the residents' shower days twice a week.</p> <p>This non-compliance was discovered during the complaint investigation.</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30809</p> <p>Based on observation, record review, staff interview, resident interview and review of facility policy, the facility failed to ensure pressure ulcer treatments were provided as ordered for one (#105) out of three residents reviewed for wounds. The facility census was 288.</p> <p>Findings include:</p> <p>Review of the medical record revealed Resident #105 was admitted on [DATE]. Diagnoses included chronic osteomyelitis with draining sinus of the left femur, pain, depression, vitamin deficiency, chronic kidney disease, prostate cancer, anorexia, and monoclonal gammopathy.</p> <p>A review of Resident #105's Minimum Data Set (MDS) dated [DATE] revealed he had intact cognition and was frequently incontinent of bowel and bladder.</p> <p>Review of Resident #105's wound assessment, dated 09/05/24, revealed a left heel stage III pressure ulcer currently measuring 0.3 centimeters (cm) long by 0.3 cm wide by 0.2 cm. deep.</p> <p>Resident #105's physician order dated 08/27/24 revealed to clean the left heel ulcer with normal saline, pat dry, pack the wound with hydroferablu, and cover with foam dressing every day shift on Tuesday, Thursday and Saturday.</p> <p>A physician order dated 09/05/24 revealed to apply the above treatment every 12 hours as needed for wound care.</p> <p>A review of Resident #105's September 2024 Treatment Administration Record (TAR) revealed the left heel wound treatment was last applied on 09/07/24 during the day shift from 7:00 A.M. to 7:00 P.M.</p> <p>An observation of Resident #105's left heel wound on 09/10/24 at 9:30 A.M. with Registered Nurse (RN) Wound Nurse #200 revealed the left heel wound bed had the hydroferablu dressing in place but no foam dressing covering the left heel pressure ulcer. RN Wound Nurse #200 verified the above finding and stated Resident #105 had an order to provide wound care as needed in the event the wound treatment was soiled or was dislodged.</p> <p>An interview with Resident #105 on 09/10/24 at 9:35 A.M. stated he didn't know the wound treatment was not present on the left heel wound and was unable to state when the wound treatment was removed from his left heel.</p> <p>Review of facility policy titled Wound Care, revised October 2010, revealed the purpose of this procedure was to provide guidelines for the care of wounds to promote healing. The preparation for wound care included verify there is a physician's order for the procedure.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00157712, Complaint Number OH00157495 and Complaint Number OH00157397. This deficiency also represents continued non-compliance from the survey dated 08/20/24.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>48567</p> <p>Based on observation, staff interview, review of the dishwasher temperature log, service manager interview, and review of the manufacturer's brochure for the facility's dishwasher, the facility failed to ensure the dishwasher reached the minimum required temperature for proper dish sanitization. This had the potential to affect all but three residents (Residents #113, #203, and #293) who received meals prepared and served by the facility. The facility census was 288.</p> <p>Findings include:</p> <p>Observation on 09/11/24 from 2:04 P.M. to 2:15 P.M. of kitchen staff washing dishes using the M-iQ Flight-type Conveyor Warewasher revealed the dishwasher exhibited two error codes throughout the observation: 1) Rinse 1 Warning 701, low temperature, and 2) Warning 710, air gap tank under-run minimum. Further random observations revealed the final rinse temperature reading did not rise above 150 degrees () Fahrenheit (F), averaging 144 F. At 2:15 P.M., Director of Dietary Services #500 removed the facility's thermometer from the dish conveyor belt, which displayed a temperature reading of 157.7 F after the final rinse, which was confirmed at the time of this observation. During this observation and interview, Director of Dietary Services #500 further confirmed the facility dishwasher was considered a high-temperature dishwasher.</p> <p>Interview on 09/11/24 at 2:15 P.M. with Assistant Director of Engineering #506 confirmed he ordered parts for the dishwasher due to staff report of the conveyor belt pausing. When asked about the expected temperature of the dishwasher, whether the pausing was the cause of the error codes, or whether the dishwasher reached the appropriate final rinse temperatures, he confirmed he would have to call the manufacturer service department for that information. Assistant Director of Engineering #506 further confirmed he did not know what the water temperature should reach on the final rinse.</p> <p>Phone interview on 09/11/24 at 2:50 P.M. with Key Account Service Manager #507 from MEIKO USA, Incorporated, confirmed the facility dishwasher was a high-temperature sanitizing machine and the final rinse temperature must meet the minimum requirement of 180 F for effective sanitization. Key Account Service Manager #507 further confirmed 1) error code number 710 meant that the dishwasher was running below the desired water level and the water was being pumped out of the tank faster than water was being pumped into the tank, and 2) error code number 701 meant the final rinse did not reach the minimum required temperature of 180 F. During the interview, Account Service Manager #507 confirmed the conveyor belt would automatically pause during the final rinse when the temperature was low.</p> <p>Observation on 09/12/24 from 9:50 A.M. to 9:55 A.M. revealed the final rinse temperature of the dishwasher never rose above 154 F.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Observation of the dishwasher in use on 09/12/24 from 10:00 A.M. to 10:05 A.M., alongside Director of Dietary Services #500, revealed final rinse temperatures ranged between 141 F and 153 F and Director of Dietary Services #500 confirmed the facility's thermometer reading was 149.9 F. The conveyor belt paused intermittently during the observation. Interview with Director of Dietary Services #500 during this observation confirmed the intermittent pausing of the conveyor belt and the water temperature of the final rinse cycle never reached the minimum requirement of 180 F. Director of Dietary Services #500 also confirmed he immediately notified the maintenance department of a final rinse temperature concern.</p> <p>Interview on 09/12/24 at 10:10 A.M. with Director of Dietary Services #500 confirmed he had noticed the water temperature was going down on 09/11/24 after making observations with the surveyor. Director of Dietary Services #500 further confirmed he maintained temperature logs but was uncertain whether dishwasher temperatures were being consistently monitored and logged. During a follow-up interview at 11:30 A.M., Director of Dietary Services #500 confirmed the dishwasher had been shut down due to low final rinse temperatures and a service call was placed to the manufacturer.</p> <p>Review of the dishwasher temperature logs for September 2024 revealed columns labeled BREAKFAST, LUNCH, and DINNER with times and temperatures logged in each row, undated. The following times and temperatures were logged below 180 F:</p> <ul style="list-style-type: none"> - Row one: 7:00 A.M. = 171 F; 12:30 P.M. = 175 F; 3:30 P.M. = 179 F - Row two: 7:30 A.M. = 179 F; 3:30 P.M. = 179 F - Row four: 12:40 P.M. = 179 F - Row five: 7:30 P.M. = 179 F; 3:30 P.M. 179 F - Row six: 1:00 P.M. = 177 F - Row nine: 12:30 P.M. 179 F - Row 10: 7:45 A.M. = 179 F; 12:4 P.M. = 174 F - Row 11: 7:30 A.M. = 176 F; 12:30 P.M. = 167 F - Row 12: 8:00 A.M. = 169 F; 10:00 A.M. = 149 F <p>No previous dishwasher logs were produced upon request.</p> <p>The facility identified three residents, Resident #113, Resident #203, and Resident #293 who did not consume food from the kitchen.</p> <p>This non-compliance was discovered during the complaint investigation.</p>		