

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 10/23/2024
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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>42730</p> <p>Based on observations, staff interviews, and review of the employee handbook, the facility failed to ensure residents were free from potential neglect when staff were sleeping while on duty. This had the potential to affect all 35 residents (#17, #27, #35, #47, #56, #62, #70, #76, #83, #92, #98, #102, #109, #120, #129, #131, #142, #143, #147, #150, #151, #161, #163, #165, #198, #213, #219, #221, #229, #231, #232, #233, #236, #246, #250) residing on the Beachwood Pavilion unit and the potential to affect all 55 residents (#3, #4, #11, #13, #18, #19, #20, #34, #36, #37, #42, #46, #54 #63, #66, #84, #86, #91, #94, #95, #99, #101, #103, #110, #113, #119, #123, #124, #126, #128, #133, #154, #156, #158, #160, #166, #168, #169, #172, #179, #181, #185, #187, #194, #199, #201, #202, #205, #210, #218, #227, #234, #238, #252, #262) residing on the Euclid Pavilion Unit. The facility census was 264.</p> <p>Findings include:</p> <p>Observation on 10/20/24 at 6:21 A.M. of the Beachwood Pavilion unit nursing station revealed Licensed Practical Nurse (LPN) #1001 was seated at the nursing station desk. The employee's head was observed tilted downward and the employee's eyes were closed. The State Surveyor attempted to arouse LPN #1001 by stating Good Morning, but LPN #1001 did not arouse. The State Surveyor attempted to arouse LPN #1001 a second time. When the LPN aroused, the State Surveyor asked LPN #1001 if he/she was sleeping, LPN #1001, smiled and rose from the desk and informed the State Surveyor the facility was sufficiently staffed, and shift change would occur at 7:00 A.M.</p> <p>Interview on 10/20/24 at approximately 6:30 A.M. with Registered Nurse (RN) #169 revealed all staff knew the rules as it pertained to sleeping on the job and all staff were provided the same employee handbook. RN #169 stated she did not know what to tell the State Surveyor as it related to the observation (of staff sleeping), but RN #169 stated I do my job and they (other staff) should do theirs.</p> <p>During the onsite survey, there were 35 residents, Resident #17, #27, #35, #47, #56, #62, #70, #76, #83, #92, #98, #102, #109, #120, #129, #131, #142, #143, #147, #150, #151, #161, #163, #165, #198, #213, #219, #221, #229, #231, #232, #233, #236, #246 and #250 who resided on the Beachwood Pavilion unit.</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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Observation on 10/20/24 at 6:33 A.M. of the Euclid Pavilion unit revealed State tested Nursing Assistant (STNA) #362 was observed sitting in a chair with the chair back against the wall. The STNA's head was observed resting on the wall, eyes closed, and mouth ajar. The State Surveyor attempted to arouse STNA #362 three times, but was unsuccessful. The State Surveyor leaned forward to speak louder in a fourth attempt to arouse STNA #362 which was successful. STNA #362 opened his/her eyes while stating residents on the unit were just waking up and getting prepared for the breakfast meal. STNA #362 confirmed, verified, and apologized for sleeping while on duty.</p> <p>Interview on 10/20/24 at 7:00 A.M. with Night Supervisor Licensed Practical Nurse (LPN) #157 revealed she had been trying to locate the State Surveyor to open the conference room. The State Surveyor informed LPN #157 that staff were observed sleeping on the night shift. No additional information was provided from the LPN in regard to staff observed sleeping on duty.</p> <p>During the onsite survey, there were 55 residents, Resident #3, #4, #11, #13, #18, #19, #20, #34, #36, #37, #42, #46, #54 #63, #66, #84, #86, #91, #94, #95, #99, #101, #103, #110, #113, #119, #123, #124, #126, #128, #133, #154, #156, #158, #160, #166, #168, #169, #172, #179, #181, #185, #187, #194, #199, #201, #202, #205, #210, #218, #227, #234, #238, #252 and #262 who resided Euclid Pavilion Unit</p> <p>Review of the employee handbook (dated 2024) employees received during orientation to the facility included a section titled Work Rules: Employee Conduct and Work Rules that revealed an infraction that may result in disciplinary action, up to and including termination of employment was sleeping while on duty. Review of the handbook revealed the infraction was listed as item Number 20 (sleeping). Review of the handbook revealed the facility did not implement the guidelines.</p> <p>Interview with administration staff, including the Administrator and the Director of Nursing (DON), during the course of the survey period dated 10/16/24 through 10/23/24 revealed during the hiring process, all new employees were educated on conduct including not sleeping while on duty.</p> <p>Review of the facility document titled Abuse, Mistreatment, Neglect, Exploitation and Misappropriation of Resident Property (last reviewed on 10/27/22), revealed the facility had a policy in place to ensure the facility provided goods and services to residents to avoid physical harm, pain, mental anguish, or emotional distress. Further review of the policy revealed all staff would be deployed, trained and qualified to meet the needs of the residents and the Administrator would ensure all situations were communicated to and coordinated with the Quality Assurance and Performance Improvement (QAPI) program and Quality Assurance Committee to determine a need for systemic action. Review of the document revealed the facility did not implement the policy to prevent potential incidents of neglect when staff were observed on duty and sleeping.</p> <p>This deficiency represents incidental findings of non-compliance investigated under Master Complaint Number OH00159014.</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>42730</p> <p>Based on observation, interview and policy review, the facility failed to ensure resident meals were palatable. This had the potential to affect 261 of 261 residents who received meal trays from the kitchen with the exception of three residents (#99, #182, #204) who the facility identified as receiving no food by mouth (NPO). The facility census was 264.</p> <p>Findings include:</p> <p>Interview on 10/16/24 at 10:15 A.M. with Resident #7 revealed the resident had concerns the food was not good and was not hot when served.</p> <p>Interview on 10/17/24 at 9:00 A.M. with Dietary Director (DD) #858 during tour of the kitchen and kitchenettes revealed the dishwasher was currently not being utilized for the cleaning and sanitizing of dishware for residents. DD #858 revealed all residents were served on disposable dishware and plastic silverware. DD #858 stated the facility was currently waiting for additional parts (timeframe for parts to arrive was not provided) to fix the dishwasher after it had not reached the required temperatures of at least 180 degrees Fahrenheit. DD #858 revealed the dishwasher was not being used to ensure the safety of the residents when it pertained to meals being served from the kitchen.</p> <p>Observation on 10/17/24 at 9:56 A.M. of the kitchen dishwasher revealed a final rise temperature of 186 degrees Fahrenheit. Observation revealed the dishwasher was safely meeting the final rinse cycle temperature to wash and sanitize dishware to serve residents in the facility. DD #858 confirmed and verified the dishwasher was meeting the appropriate rinse cycle temperature.</p> <p>Interview and observation on 10/17/24 at 9:58 A.M. with Dietary Supervisor (DS) #812 revealed the dishwasher was maintaining a final rinse cycle of 186 degrees Fahrenheit, but the facility was continuing to use disposable dishware to serve residents meals. Observation of a wash and rinse cycle at the time of the interview revealed the dishwasher was currently maintaining a final rinse cycle of 186 degrees Fahrenheit. DS #812 revealed the minimum temperature should be 180 degrees Fahrenheit. DS #812 confirmed and verified the observation at the time of the interview.</p> <p>Interview on 10/17/24 at 10:10 A.M. with the Administrator revealed the dishwasher issues regarding the final rinse cycle meeting required temperatures were actually resolved (date not provided) but she made the executive decision to not utilize the dishwasher for dishware until the entire dishwasher was fixed in entirety (the facility had parts on order for additional work on the dishwasher at the time of the survey). The Administrator revealed she was not using the dishwasher as a precaution.</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Observation on 10/17/24 at 11:25 A.M. with Dietary Director (DD) #858 of the tray line revealed the lunch meal consisted of breaded tilapia, green beans, grilled cheese, chopped potatoes, rice, and a chocolate brownie. All food items were checked, and the following temperatures were recorded at the steam table: the tilapia was 167 degrees Fahrenheit, the chopped potatoes were 174 degrees Fahrenheit, the grilled cheese was 150 degrees Fahrenheit, the rice was 182 degrees Fahrenheit, and the green beans were 184 degrees Fahrenheit. All food items were plated on disposable dishware with a plastic dome top, without warming plates, and placed in the travel carts to be dispersed to each unit for serving.</p> <p>A test tray of the lunch meal was completed on 10/17/24 at 11:50 A.M. with DD #858 on the memory care unit. The test tray included breaded tilapia, green beans and grilled cheese. DD #858 utilized a digital thermometer to check the temperatures of the food items. The breaded tilapia was 123 degrees Fahrenheit, the grilled cheese was 118 degrees Fahrenheit, and the green beans were 121 degrees Fahrenheit. The food items were flavorful, however they were only warm and not hot. The temperatures had dropped in temperature in comparison to the temperatures taken at the steam table. DD #858 confirmed and verified the food items were not hot at the time of the observation of the test tray.</p> <p>Interview on 10/17/24 at 12:31 P.M. with Resident #87 revealed concerns with meal temperatures. The resident stated staff had to re-warm her breakfast due to the eggs being cold and this had been occurring for awhile.</p> <p>Interview on 10/17/24 at 12:33 P.M. with Residents #36, #199, and #205 revealed the meals served from the kitchen were barely hot and sometimes needed reheated in the microwave.</p> <p>Interview on 10/17/24 at 12:35 P.M. with Resident #126 revealed the food was horrible.</p> <p>Interview on 10/17/24 at 12:36 P.M. with Resident #54 revealed the meals were awful, not hot enough and sometimes served cold.</p> <p>Interview on 10/17/24 at 12:38 P.M. with Resident #243 revealed the food was not hot most of the time.</p> <p>Interview on 10/17/24 at 12:40 P.M. with Resident #118 revealed the food was served hot sometimes.</p> <p>Interview on 10/17/24 at 12:44 P.M. with Resident #89 revealed the food was not hot and it did not pertain to any specific meal.</p> <p>Interview on 10/17/24 at 12:46 P.M. with Resident #190 revealed the meals from the kitchen were served cold and he could not eat it.</p> <p>Interview on 10/17/24 at 12:47 P.M. with Resident #188 revealed she was upset about the lunch meal today due to her fries (chopped potatoes) being cold and greasy. Resident #188 revealed her food was cold most of the time.</p> <p>Interview on 10/17/24 at 12:50 P.M. with Resident #226 revealed she was upset with her lunch meal. Resident #226 revealed her food was normally cold, especially breakfast, and she had to have staff re-warm her food.</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> <p>Note: The nursing home is disputing this citation.</p>	<p>A telephone interview on 10/17/24 at 4:06 P.M. with a General Parts Group Technician revealed he was able to access the information to the facility and services provided. Interview revealed the facility dishwasher previously had an issue with keeping the rinse cycle temperature sustained at a safe temperature (180 degrees Fahrenheit) and was reading between 164 degrees Fahrenheit and 166 Fahrenheit degrees. Interview revealed the flow of water needed to be regulated and it required no additional parts to correct. The technician revealed at the time of service on 10/15/24, the onsite technician switched the gate valve to regulate the flow of water, and the rinse cycle temperatures were corrected and held steady. Follow-up visits to the facility were not related to the dishwasher rinse cycle, however, it required continued service due to the conveyor belt running slowly. Interview revealed the conveyor belt concern with the dishwasher did not affect the rinse cycle temperatures, the issue was resolved.</p> <p>The service of food on disposable plates resulting in food being served that was not hot and palatable after the facility dishwasher was repaired and functioning affected all residents, except three residents (#99, #182, #204) who the facility identified as receiving no food by mouth (NPO).</p> <p>Review of the facility document titled Food Preparation and Service (revised November 2022), revealed the facility had a policy in place that food would be prepared, distributed, and served in a manner that complied with safe food handling practices. Review of the policy revealed the danger zone for food temperatures was above 41 degrees Fahrenheit and below 135 degrees Fahrenheit due to the temperature range promoted rapid growth of pathogenic microorganism that caused food borne illnesses.</p> <p>This deficiency represents incidental findings of non-compliance investigated under Master Complaint Number OH00159014.</p>

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p>42730</p> <p>Based on observation, review of the job descriptions, review of the employee handbook, and interviews, the facility failed to have systems in place to ensure it was administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Administrative staff failed to ensure staff did not sleep while on duty, failed to ensure staff did not have and/or utilize phones for personal use in resident care areas of the facility and failed to ensure the kitchen dishwasher was utilized timely after repairs to ensure meals were not served on disposable plates resulting in food being served from the kitchen that was not palatable.</p> <p>This affected 15 residents (#95, #7, #87, #36, #103, #199, #205, #126, #54, #243, #118, #89, #226, #190 and #188) and had the potential to affect all 264 facility residents residing in the facility which included 35 residents who resided on the Beachwood Pavilion unit and 55 residents who resided on the Euclid Pavilion unit. The facility census was 264.</p> <p>Findings include:</p> <p>Review of the undated job description for the Administrator revealed the Administrator reported to the Chief Executive Officer (CEO) and essential job functions included, but were not limited to, overseeing and ensuring the facility adhered to standards, norms, and government agency regulatory expectations, and to ensure patient safety, and healthcare quality.</p> <p>Review of the undated job description for the Director of Nursing (DON) revealed the DON reported to the Chief Operating Officer (COO) and was responsible for assuring the residents care was optimal and met and/or exceeded standards of nursing practice that included, but not limited to, providing supervision, guidance, and direction to resident units and nursing personnel within each unit, assess, evaluate and improve resident care, responsible for training, in-servicing, and evaluating staff.</p> <p>Interviews with administrative staff, including the Administrator and the DON, during the course of the survey period dated 10/16/24 through 10/23/24 revealed administration staff were aware of ongoing concerns due to previous deficiencies issued by the State agency regarding staff on cell phones, dishwasher maintenance and repair, and acknowledged during the hiring process, all new employees were educated on conduct including personal use of cell phones while on duty.</p> <p>The following new and continued concerns were identified during the on-site complaint survey and correlated to a lack of effective administrative oversight:</p> <p>a. Observation on 10/20/24 at 6:21 A.M. of the Beachwood Pavilion unit nursing station revealed Licensed Practical Nurse (LPN) #1001 was seated at the nursing station desk. The employee's head was observed tilted downward and the employee's eyes were closed. The State Surveyor attempted to arouse LPN #1001 by stating Good Morning, but LPN #1001 did not arouse. The State Surveyor attempted to arouse LPN #1001 a second time. When the LPN aroused, the State Surveyor asked LPN #1001 if he/she was sleeping, LPN #1001, smiled and rose from the desk and informed the State Surveyor the facility was sufficiently staffed, and shift change would occur at 7:00 A.M.</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Interview on 10/20/24 at approximately 6:30 A.M. with Registered Nurse (RN) #169 revealed all staff knew the rules as it pertained to sleeping on the job and all staff were provided the same employee handbook. RN #169 stated she did not know what to tell the State Surveyor as it related to the observation (of staff sleeping), but RN #169 stated I do my job and they (other staff) should do theirs.</p> <p>During the onsite survey, there were 35 residents, Resident #17, #27, #35, #47, #56, #62, #70, #76, #83, #92, #98, #102, #109, #120, #129, #131, #142, #143, #147, #150, #151, #161, #163, #165, #198, #213, #219, #221, #229, #231, #232, #233, #236, #246 and #250 who resided on the Beachwood Pavilion unit.</p> <p>Observation on 10/20/24 at 6:33 A.M. of the Euclid Pavilion unit revealed State tested Nursing Assistant (STNA) #362 was observed sitting in a chair with the chair back against the wall. The STNA's head was observed resting on the wall, eyes closed, and mouth ajar. The State Surveyor attempted to arouse STNA #362 three times, but was unsuccessful. The State Surveyor leaned forward to speak louder in a fourth attempt to arouse STNA #362 which was successful. STNA #362 opened his/her eyes while stating residents on the unit were just waking up and getting prepared for the breakfast meal. STNA #362 confirmed, verified, and apologized for sleeping while on duty.</p> <p>Interview on 10/20/24 at 7:00 A.M. with Night Supervisor Licensed Practical Nurse (LPN) #157 revealed she had been trying to locate the State Surveyor to open the conference room. The State Surveyor informed LPN #157 that staff were observed sleeping on the night shift. No additional information was provided from the LPN in regard to staff observed sleeping on duty.</p> <p>During the onsite survey, there were 55 residents, Resident #3, #4, #11, #13, #18, #19, #20, #34, #36, #37, #42, #46, #54 #63, #66, #84, #86, #91, #94, #95, #99, #101, #103, #110, #113, #119, #123, #124, #126, #128, #133, #154, #156, #158, #160, #166, #168, #169, #172, #179, #181, #185, #187, #194, #199, #201, #202, #205, #210, #218, #227, #234, #238, #252 and #262 who resided Euclid Pavilion Unit</p> <p>Review of the employee handbook (dated 2024) employees received during orientation to the facility included a section titled Work Rules: Employee Conduct and Work Rules that revealed an infraction that may result in disciplinary action, up to and including termination of employment was sleeping while on duty. Review of the handbook revealed the infraction was listed as item Number 20 (sleeping). Review of the handbook revealed the facility did not implement the guidelines.</p> <p>Interview with administration staff, including the Administrator and the Director of Nursing (DON), during the course of the survey period dated 10/16/24 through 10/23/24 revealed during the hiring process, all new employees were educated on conduct including not sleeping while on duty.</p> <p>b. Observation on 10/20/24 at 6:24 A.M. of the Beachwood Pavilion unit revealed STNA #374 was observed sitting in the common area/dining room with a personal cell phone in the employee's hand and face illuminated by the light from the phone. There were four (unidentified) residents also present in the area. As the State Surveyor approached STNA #374, the cell phone was dimmed and placed in the pocket of STNA #374's scrub pants. An interview with the STNA at the time of the observation verified she had been using her phone and stated she was checking something.</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Interview on 10/20/24 at approximately 6:30 A.M. with Registered Nurse (RN) #169 revealed staff knew the rules as it pertained to talking on the phone as all staff were provided the same employee handbook. RN #169 revealed she did not know what to tell the State Surveyor as it related to the observations (of staff using their cell phone), but RN #169 stated I do my job and they (other staff) should do theirs.</p> <p>Observation on 10/20/24 at 6:36 A.M. of the Euclid Pavilion unit revealed STNA #170 was observed inside Resident #95's bathroom. Resident #95 was observed laying in bed. STNA #170 was heard from the hallway talking loudly but conversation details were unclear. Resident #95 appeared sleep and not engaging in conversation with STNA #170. STNA #170 was observed exiting Resident #95 room with a telephone earpiece in the right ear. When the State Surveyor asked STNA #170 if they were on their phone, STNA #170 stated they were not aware that State Surveyors visited facilities early or on the weekends. STNA #170 did not answer or acknowledge the State Surveyor inquiry into phone use.</p> <p>Interview on 10/20/24 at 7:00 A.M. with Night Supervisor LPN #157 revealed she had been trying to locate state surveyor to open the conference room. The State Surveyor informed LPN #157 that staff were seen utilizing their personal phones while on duty. LPN #157 revealed that staff were just informed of phone use due to previous citations and all staff were aware of the phone policy upon hire.</p> <p>Interview on 10/23/24 at 11:18 A.M. with Registered Nurse (RN) #169 revealed she disciplined staff in the past for using their phone while working but could not remember dates or staff names.</p> <p>Interview on 10/23/24 at 2:02 P.M. with Resident #103 revealed he had seen staff on their phones sometimes, but he stated he tried not to acknowledge it because he did not like it.</p> <p>Review of the undated job description for STNAs revealed the STNA reported to the nursing manager and/or supervisor, and the DON and Assistant Director of Nursing (ADON). Review of the job description revealed STNAs were responsible for providing a safe environment for residents and monitoring the environment for safety.</p> <p>Review of the employee handbook employees received during orientation to the facility, dated 2024, included a section titled Work Rules: Employee Conduct and Work Rules that revealed an infraction that may result in disciplinary action, up to and including termination of employment, was receiving or making personal calls while on duty. Review of the handbook revealed the infraction was listed as item Number 47 (phones). Review of the handbook revealed the facility did not implement the guidelines.</p> <p>c. Interview on 10/16/24 at 10:15 A.M. with Resident #7 revealed the resident had concerns the food was not good and was not hot when served.</p> <p>Interview on 10/17/24 at 9:00 A.M. with Dietary Director (DD) #858 during tour of the kitchen and kitchenettes revealed the dishwasher was currently not being utilized for the cleaning and sanitizing of dishware for residents. DD #858 revealed all residents were served on disposable dishware and plastic silverware. DD #858 stated the facility was currently waiting for additional parts (timeframe for parts to arrive was not provided) to fix the dishwasher after it had not reached the required temperatures of at least 180 degrees Fahrenheit. DD #858 revealed the dishwasher was not being used to ensure the safety of the residents when it pertained to meals being served from the kitchen.</p> <p>(continued on next page)</p>		

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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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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Observation on 10/17/24 at 9:56 A.M. of the kitchen dishwasher revealed a final rise temperature of 186 degrees Fahrenheit. Observation revealed the dishwasher was safely meeting the final rinse cycle temperature to wash and sanitize dishware to serve residents in the facility. DD #858 confirmed and verified the dishwasher was meeting the appropriate rinse cycle temperature.</p> <p>Interview and observation on 10/17/24 at 9:58 A.M. with Dietary Supervisor (DS) #812 revealed the dishwasher was maintaining a final rinse cycle of 186 degrees Fahrenheit, but the facility was continuing to use disposable dishware to serve residents meals. Observation of a wash and rinse cycle at the time of the interview revealed the dishwasher was currently maintaining a final rinse cycle of 186 degrees Fahrenheit. DS #812 revealed the minimum temperature should be 180 degrees Fahrenheit. DS #812 confirmed and verified the observation at the time of the interview.</p> <p>Interview on 10/17/24 at 10:10 A.M. with the Administrator revealed the dishwasher issues regarding the final rinse cycle meeting required temperatures were actually resolved (date not provided) but she made the executive decision to not utilize the dishwasher for dishware until the entire dishwasher was fixed in entirety (the facility had parts on order for additional work on the dishwasher at the time of the survey). The Administrator revealed she was not using the dishwasher as a precaution.</p> <p>Interview on 10/17/24 at 12:31 P.M. with Resident #87 revealed concerns with meal temperatures. The resident stated staff had to re-warm her breakfast due to the eggs being cold and this had been occurring for awhile.</p> <p>Interview on 10/17/24 at 12:33 P.M. with Residents #36, #199, and #205 revealed the meals served from the kitchen were barely hot and sometimes needed reheated in the microwave.</p> <p>Interview on 10/17/24 at 12:35 P.M. with Resident #126 revealed the food was horrible.</p> <p>Interview on 10/17/24 at 12:36 P.M. with Resident #54 revealed the meals were awful, not hot enough and sometimes served cold.</p> <p>Interview on 10/17/24 at 12:38 P.M. with Resident #243 revealed the food was not hot most of the time.</p> <p>Interview on 10/17/24 at 12:40 P.M. with Resident #118 revealed the food was served hot sometimes.</p> <p>Interview on 10/17/24 at 12:44 P.M. with Resident #89 revealed the food was not hot and it did not pertain to any specific meal.</p> <p>Interview on 10/17/24 at 12:46 P.M. with Resident #190 revealed the meals from the kitchen were served cold and he could not eat it.</p> <p>Interview on 10/17/24 at 12:47 P.M. with Resident #188 revealed she was upset about the lunch meal today due to her fries being cold and greasy. Resident #188 revealed her food was cold most of the time.</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Interview on 10/17/24 at 12:50 P.M. with Resident #226 revealed she was upset with her lunch meal. Resident #226 revealed her food was normally cold, especially breakfast, and she had to have staff re-warm her food.</p> <p>The service of food on disposable plates resulting in food being served that was not hot and palatable after the facility dishwasher was repaired and functioning affected all residents, except three residents (#99, #182, #204) who the facility identified as receiving no food by mouth (NPO).</p> <p>A telephone interview on 10/17/24 at 4:06 P.M. with a General Parts Group Technician revealed he was able to access the information to the facility and services provided. Interview revealed the facility dishwasher previously had an issue with keeping the rinse cycle temperature sustained at a safe temperature (180 degrees Fahrenheit) and was reading between 164 degrees Fahrenheit and 166 Fahrenheit degrees. Interview revealed the flow of water needed to be regulated and it required no additional parts to correct. The technician revealed at the time of service on 10/15/24, the onsite technician switched the gate valve to regulate the flow of water, and the rinse cycle temperatures were corrected and held steady. Follow-up visits to the facility were not related to the dishwasher rinse cycle, however, it required continued service due to the conveyor belt running slowly. Interview revealed the conveyor belt concern with the dishwasher did not affect the rinse cycle temperatures, the issue was resolved.</p> <p>The facility failed to ensure effective administrative services were in place to monitor the service to the dish machine to allow for staff to timely resume normal operation of the dish machine and discontinue the use of disposable service ware to ensure food was served at the proper temperature and palatable .</p> <p>This deficiency represents incidental findings of non-compliance investigated under Master Complaint Number OH00159014.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47568</p> <p>Based on observation, record review, review of the facility policy, review of the Centers for Medicare and Medicaid (CMS) directive related to Enhanced Barrier Precautions (EBP) and interview, the facility failed to develop and implement an effective infection control program to ensure enhanced barrier precautions (EBP) were maintained while wound care was performed for Resident #67. This affected one resident (#67) of three residents reviewed for wound care. The facility census was 264.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #67 revealed an admitted [DATE]. Diagnoses included multiple sclerosis, cognitive communication deficit, Crohn's disease, unspecified severe protein calorie malnutrition, Parkinson's disease, major depressive disorder and neuromuscular dysfunction of bladder.</p> <p>Review of the quarterly Minimum Data Set (MDS) 3.0 assessment completed on 10/01/24 revealed Resident #67 had intact cognition and was dependent on staff for activities of daily living. Resident #67 had an indwelling urinary catheter, and two unhealed Stage II pressure ulcers that were present on admission.</p> <p>Review of the physician's orders for Resident #67 revealed no physician orders for EBP were in place related to suprapubic catheter use and wounds care.</p> <p>Review of the care plan dated 06/21/24 revealed Resident #67 had an actual pressure wound present on admission as well as a suprapubic catheter due to neurogenic bladder. Intervention included to maintain EBP while performing high-contact resident care activities.</p> <p>Observation on 10/17/24 from 8:15 A.M. to 8:20 A.M. revealed Licensed Practical Nurse (LPN) #835 knocked on Resident #67's door and entered. While Registered Nurse (RN) #842 was gathering needed supplies, LPN #835 cleansed the resident's bedside table. RN #842 placed wound care supplies on bedside table and both LPN #835 and RN #842 then washed their hands and applied (donned) gloves (no gown was applied), then both staff proceeded to assist Resident #67 to turn onto the resident's side to allow RN #842 to complete the dressing changes. RN #842 removed soiled dressings, removed (doffed) gloves, cleansed hands and donned clean gloves. Nurse Practitioner (NP) #1000, who was present also, was observed to cleanse his/her hands and donned gloves (no gown applied) then proceeded to measure Resident #67's hip and coccyx wound. RN #842 then placed new dressings on the resident's coccyx and hip wounds. RN #842, LPN #835 and NP #1000 removed their gloves, performed hand hygiene and exited the resident's room.</p> <p>Interview on 10/16/24 at 8:22 A.M. with RN #842, LPN #835, and NP #1000 confirmed they did not wear gowns while performing high contact (wound) care for Resident #67. RN #842 further stated she had not worn a gown since Resident #67 did not have Methicillin-Resistant Staphylococcus aureus (MRSA).</p> <p>Interview on 10/17/24 at 3:23 P.M. with the Director of Nursing (DON) revealed the staff did not write an actual physician order for EBP; however, the need for EBP was identified in the resident's plan of care.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of facility policy titled Enhanced Barrier Precautions, dated 04/01/24, revealed enhanced barrier precautions were used in conjunction with standard precautions and expand the use of personal protective equipment (PPE) to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of multi-drug-resistant organisms (MDROs) to staff hands and clothing. EBP was indicated for residents with wounds and indwelling medical devices such as urinary catheters.</p> <p>Review of the Centers for Medicare and Medicaid, Center for Clinical Standards and Quality/Quality, Safety & Oversight (QSO) Group memorandum summary, reference number QSO-24-08-NH, issued 03/20/24, revealed EBP in long-term care facilities became effective on 04/01/24 to align with nationally accepted standards. The QSO memorandum further revealed EBP was to include residents with chronic wounds and/or indwelling medical devices, including feeding tubes and tracheostomies, during high contact care regardless of their status related to multi-drug-resistant organisms.</p> <p>This deficiency represents incidental findings of non-compliance investigated under Complaint Number OH00158514.</p>