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	01/16/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011 Based on interview, record review, and review of the facility policy, the facility failed to ensure Resident #138's physician and responsible party was notified of a change in condition. This affected one resident (Resident #138) of three residents reviewed for a change in condition. The facility census was 277. Findings include: Record review for Resident #138 revealed an admitted [DATE]. Diagnosis included need for assistants with personal care, stress incontinence, and morbid severe obesity. Observation on 01/13/25 at 11:26 A.M. of incontinent care for Resident #138 provided by Certified Nursing Assistant (CNA) #748 revealed Resident #138 had an open area to the right anterior/medial thigh. The open area was actively bleeding a small amount serosanguinous drainage. No treatment was observed to the area. CNA #748 revealed she worked on Saturday, 01/11/25, and the same open area was there then. CNA #748 wiped off the wound during incontinent care while Resident #138 revealed the area was painful. Observation on 01/13/25 between 11:48 A.M. and 12:29 P.M. of the wound on Resident #138's right anterior/medial thigh with Licensed Practical Nurse (LPN) #790 confirmed the wound was open and bleeding. LPN #790 revealed she was Resident #138's primary care nurse and revealed she was unaware of the wound to that area. LPN #790 confirmed Resident #138 did not have a treatment order for the specified wound. Record review on 01/15/25 at 4:28 P.M. for Resident #138 (of the physician orders, Medication Administration Record (MAR), Treatment Administration Record (TAR) progress notes and Assessments), with Assistant Director of Nursing (ADON) #744, (DON present), confirmed there was no documentation of the open area on the anterior/medial thigh, no treatment, or physician/family notification of the open area on Resident #138's anterior thigh after the area was found on 01/11/25 through 01/13/25 at 11:26 A.M. (during the observation of incontinent care with the surveyor) . DON and ADON #744 confirmed Wound Care Nurse #377 was notified of the open area to the anterior thigh on 01/11/25 but the physician or family was not notified, and no treatment was initiated prior to the surveyor observation on 01/13/25 at 11:26 A.M. (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

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 01/16/2025

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King David Post Acute Nursing & Rehabilitation LLC	27100 Cedar Rd Beachwood, OH 44122

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Phone interview on 01/15/25 at 4:50 P.M. with Wound Care Nurse #377 confirmed she was made aware of the open area to Resident #138's thigh on Saturday, 01/11/25 by the floor Supervisor. Wound Care Nurse #377 revealed the open area was due to moisture. Review of the facility policy titled, Change in Resident's Condition or Status revised February 2021 revealed the facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and or status. The nurse will record in the residents medical record information related to changes in the resident's medical/mental condition or status. This deficiency represents non-compliance investigated under Complaint Number OH00161351.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011 Based on observation, interview, record review, and review of the facility policy, the facility failed to timely assess and provide wound care for Resident #138. This affected one resident (Resident #138) of three residents reviewed for incontinence care. The facility census was 277. Findings include: Record review for Resident #138 revealed an admitted [DATE]. Diagnosis included need for assistants with personal care, stress incontinence, and morbid severe obesity. Review of the significant change Minimum Data Set (MDS) dated [DATE] revealed Resident #138 was cognitively intact. Resident #138 used a wheelchair for mobility, required partial/moderate assistants for toileting hygiene, and dependent for personal hygiene. Resident #138 was frequently incontinent of bowel and bladder. Resident #138 was at risk for pressure ulcers/injuries. Record review of the care plan dated 06/10/24 revealed Resident #138 had potential for impaired skin integrity. Interventions included to provide skin care per facility guidelines. Review of the Weekly Skin Check completed 01/08/25 by Registered Nurse (RN) #717 revealed Resident #138's skin was intact. Record review of the progress notes and assessments for Resident #138 from 01/07/24 through 01/13/24 at 12:00 P.M. revealed no documentation of open areas to Resident #138 anterior thigh. Review of the physician orders for Resident #138 revealed no order for a treatment to Resident #138's open area to the anterior/medial right thigh. Observation on 01/13/25 at 11:26 A.M. of incontinent care for Resident #138 provided by Certified Nursing Assistant (CNA) #748 revealed Resident #138 had an open area to the right anterior/medial thigh. The open area was actively bleeding a small amount serosanguinous drainage. No treatment was observed to the area. CNA #748 revealed she worked on Saturday, 01/11/25, and the same open area was there then. CNA #748 wiped off the wound during incontinent care while Resident #138 revealed the area was painful. Observation on 01/13/25 between 11:48 A.M. and 12:29 P.M. with Licensed Practical Nurse (LPN) #790 of the wound on Resident #138's right anterior/medial thigh confirmed the wound was open and bleeding. LPN #790 revealed she was Resident #138's primary care nurse and revealed she was unaware of the wound to that area. LPN #790 confirmed Resident #138 did not have a treatment order for the specified wound. Observation revealed LPN #790 measured the wound and LPN #790 revealed the wound measured 1.7 centimeters (cm) in length by 0.5 cm in width by 0.5 cm in depth. (continued on next page)

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review on 01/15/25 at 4:28 P.M. for Resident #138 (of the physician orders, Medication Administration Record (MAR), Treatment Administration Record (TAR) progress notes and Assessments), with Assistant Director of Nursing (ADON) #744, (DON present), confirmed there was no documentation of the open area on the anterior/medial thigh, no treatment, or physician/family notification of the open area on Resident #138's anterior thigh after the area was found on 01/11/25 through 01/13/25 at 11:26 A.M. (during the observation of incontinent care with the surveyor). DON and ADON #744 confirmed Wound Care Nurse #377 was notified of the open area to the anterior thigh on 01/11/25 but the physician or family was not notified, and no treatment was initiated prior to the surveyor observation on 01/13/25 at 11:26 A.M. DON confirmed a treatment should have been initiated on 01/11/25 after the wound was found to be open. Phone interview on 01/15/25 at 4:50 P.M. with Wound Care Nurse #377 confirmed she was made aware of the open area to Resident #138's thigh on Saturday, 01/11/25 by the floor Supervisor. Wound Care Nurse #377 revealed the open area was due to moisture. Review of the facility policy tilted, Wound Care, revised October 2010, revealed the purpose of the procedure was to provide guidelines for the care of wounds to promote healing. Documentation of the wound included type of wound care given, the date and time the wound care was given, the position in which the resident was placed, the name of the individual performing wound care, any change in the resident's condition, all assessment data (wound bed color, size, drainage, etc.) obtained when inspecting the wound, how the resident tolerated the procedure, any complaints or problems made by the resident related to the procedure, if the resident refused the treatment and the reason why, and the signature and title of the person recording the data. Reporting requirements included notify the supervisor if the resident refused wound care and report other information in accordance with facility policy and professional standards of practice. Review of the facility policy titled, Change in Resident's Condition or Status revised February 2021 revealed the facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and or status. The nurse will record in the residents medical record information related to changes in the resident's medical/mental condition or status. This deficiency represents non-compliance investigated under Complaint Number OH00161351.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011 Based on medical record review, interview, review of a video recording, review of the facility investigation report, and review of the facility policy, the facility failed to administer Resident #85 and Resident #155's medications per physician orders. This affected two residents (Resident #155 and #85) of three residents reviewed for pharmacy services. The facility census was 277. Findings include: 1. Record review for Resident #155 revealed an admission of 02/03/22. Diagnosis included unspecified convulsions, atherosclerotic heart disease, and constipation. Review of the quarterly MDS dated [DATE] revealed Resident #155 was cognitively intact. Resident #155 required extensive assistance for bed mobility, transfers, and toilet use. Review of the physician orders for Resident #155 revealed orders for Atorvastatin calcium tablet 40 milligrams (mg) give 1 tablet by mouth in the evening related to atherosclerotic heart disease ordered 11/26/23; scheduled to be given from 7:00 P.M. to 11:00 P.M., Polyethylene Glycol 3350 powder give 34 grams by mouth two times a day for constipation ordered 11/26/23; scheduled to be given from 8:00 P.M. to 10 :00 P.M., Senna Docusate Sodium tab 8.6-50 mg give two tablets by mouth two times a day for constipation ordered 11/26/23; scheduled be given from 8:00 P.M. to 10 :00 P.M., and Depakote oral tablet delayed release 250 mg give one tablet by mouth three times a day for seizures, ordered 11/13/24 and scheduled to be given 9:00 A.M., 2:00 P.M. and 9:00 P.M. Review of the Medication Administration Record (MAR) for Resident #155 for 01/10/25 revealed the medications were signed off as administered per the physicians orders (indicated by a check mark and the nurses initial for the date and time administered). No medications were administered between 1:00 A.M. and 3:00 A.M. including as needed (prn) medications. Review of the Medication Administration Audit Report (revealed the exact time the medication was documented as administered) for Resident #155 revealed Atorvastatin calcium was administered at 10:52 P. M., Polyethylene Glycol 3350 powder was administered at 10:52 P.M., Senna docusate sodium tab was administered at 10:52 P.M., and Depakote oral tablet delayed release was administered at 10:52 P.M. Review of an undated video recording of Resident #155 revealed a person was administering medications to Resident #155. In the video Resident #155 asked the person administering the medication what time it was. The person responded it was Saturday, 1:56 (A.M.) in the morning. Interview on 01/14/25 at 3:13 P.M. with Resident #155's daughter revealed Resident #155 had a camera in his room for monitoring and on 01/10/25 Resident #1:55 did not receive his evening medications until almost 2:00 A.M. Resident #155's daughter revealed she called the nursing supervisor three times that evening to request the nurse to offer Resident #155 his evening medications. The last call was 1:00 A.M., and the nursing supervisor told her there must have just been a misunderstanding to why the charge nurse did not administer the medication. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Phone interview on 01/14/25 at 3:36 P.M. with LPN Nursing Supervisor #353 confirmed she worked on 01/10/25 from 7:00 P.M. to 7:00 A.M. Nursing Supervisor #353 revealed everyone got their medications on time on Friday 01/10/24 night shift. Nursing Supervisor #353 confirmed she spoke with Resident #155's daughter on 01/10/25, but she could not remember what the concerns or conversations were regarding. On 01/14/25 at 4:30 P.M. the video recording of Resident #155 was reviewed with Assistant Director of Nursing (ADON) #744 who revealed the nurse administering the medications to Resident #155 was Licensed Practical Nurse (LPN) #791. ADON #744 confirmed the MAR did not reflect any medications being administered between 1:00 A.M. and 3:00 A.M. Review of the Investigation Summary for Resident #155 provided on 01/15/24 by DON dated 01/14/25 revealed the description of the event included Resident #155 and medications received by LPN #791. Investigation findings included during the medication pass (01/10/25) LPN #791 was getting ready to go into Resident #155's room when she noted another resident in distress. The nurse revealed she completed the medication pass around 10:50 P.M., she then remembered at 1:54 A.M. that she forgot to give Resident #155 his medications. The nurse stated she signed off the medications because she was walking in the room to give the medications when the emergency occurred. The physician was notified. DON confirmed the medications were administered late. Each medication was signed off on the MAR as given on 01/10/25 at 10:52 P.M. but the medications were not administered until 01/11/25 at approximately 1:56 A.M.; DON confirmed there were sufficient nursing staff available, including the supervisor to assist with medication administration when an emergency occurred to assure medications were administered timely. DON confirmed there was no documentation in Resident #155's medical records disclosing the time the medications were actually administered nor notifications of the physician being notified. Review of the guidance titled, Depakote Drug Profile and Side Effects, dated 09/18/23, revealed Depakote ER helps prevent brain cells from working as fast as a seizure requires them to. In this way, seizures can be stopped when they are just beginning. People with conditions including epilepsy have to take medications when they need it and often at a specific time (time critical medication). If a dose is missed or taken late, they risk becoming more unwell, sometimes irreversibly. Review of the facility policy titled, Administering Medications,revised April 2019, revealed medications are administered in a safe and timely manner, and as prescribed. Staffing schedules are arranged to ensure that medications are administered without unnecessary interruptions. Medications are administered in accordance with prescriber orders, including any required time frame. Medications are administered within one hour of their prescribed times unless otherwise specified. The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones. 2. Record review for Resident #85 revealed an admitted [DATE]. Diagnosis included atrial fibrillation, diabetes mellitus with diabetic polyneuropathy, and vitamin d deficiency. Review of the quarterly MDS dated [DATE] revealed Resident #85 was cognitively intact. Resident #85 used a wheelchair for mobility and required set up or clean up assist with meals. (continued on next page)

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the physician orders for Resident #85 revealed orders for Eliquis (anticoagulant) five mg one tablet by mouth two times a day ordered 11/19/23; scheduled to be given from 8:00 A.M. to 10:00 A.M. and 8:00 P. M. to 10:00 P.M., Metformin 1000 mg tablet one time a day related to type two diabetes mellitus with diabetic polyneuropathy ordered 08/07/23; scheduled to be given at 8:00 A.M., Vitamin D 50 micrograms (mcg) give one tablet by mouth one time a day for vitamin d deficiency ordered 06/26/24; scheduled to be given from 8:00 A.M. to 10:00 A.M., and Lactobacillus give one tablet by mouth two times a day for gastrointestinal health ordered 11/19/23; scheduled to be given from 8:00 A.M. to 10:00 A.M. and 8:00 P.M. to 10:00 P.M. Review of the Medication Administration Audit Report (revealed the exact time the medication was documented as administered) dated 01/12/25 for Resident #85 revealed Eliquis, Metformin, Vitamin D and Lactobacillus was not administered until 11:58 A.M. by Registered Nurse (RN) #443. Interview on 01/13/25 at 1:16 P.M. with Resident #85 revealed it was important to her to receive her medications timely and on 01/12/24 she did not receive her A.M. medications until 12:00 P.M. and RN #443 was the nurse at the time. Interview on 01/13/25 at 1:28 P.M. with RN #443 confirmed on 01/12/24 Resident #85 did not receive her A. M. medications until 11:58 A.M RN #443 revealed she did not recall why they were late, there was no specific reason, she was just dealing with issues which can throw the medications off. RN #443 revealed sometimes she just gets busy and residents' medications were administered late. Review of the National Institutes of Health guidance for Eliquis, dated 2023, revealed recommendations to take Eliquis exactly as prescribed at the same time everyday in the morning and at night. Review of the facility policy titled, Administering Medications, revised April 2019, revealed medications are administered in a safe and timely manner, and as prescribed. Staffing schedules are arranged to ensure that medications are administered without unnecessary interruptions. Medications are administered in accordance with prescriber orders, including any required time frame. Medications are administered within one hour of their prescribed times unless otherwise specified. The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones. This deficiency represents non-compliance investigated under Complaint Number OH00161278, OH00161166, and OH00161595.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011 Based on medical record review, observation, staff interview, and review of the facility policy, the facility failed physician orders were followed and the medication error rate did not exceed five percent (%). The facility had four medication errors of 30 opportunities for an error rate of 13.33%. This affected three residents (Resident #8, Resident #127, and Resident #271) of nine residents observed for medication administration. The facility census was 277 residents. Findings include: 1. Record review for Resident #8 revealed an admitted [DATE]. Diagnosis included Parkinson's, cerebral infarction, and muscle weakness. Review of the Clinical Admission assessment completed 01/08/25 revealed Resident #8 was verbal, oriented to person, place, and required cues. Review of the physician orders for Resident #8 revealed Resident #8 had an order dated 01/10/25 for Aspirin 81 milligram (mg) oral tablet give one tablet by mouth in the morning for Parkinson's; scheduled to be given between 8:00 A.M. and 11:00 A.M., and an additional order for Fish Oil oral capsule 500 mg (Omega-3 Fatty Acids) give one capsule by mouth in the morning for supplement; scheduled to be given between 8:00 A.M. and 11:00 A.M. Observation on 01/14/25 at 9:42 A.M. of medication administration revealed Registered Nurse (RN) #792 did not administer Resident #8's Aspirin or Fish Oil, indicating Resident #8 did not have Aspirin 81 mg or Fish Oil oral capsule 500 mg available for administration. Interview on 01/15/25 at 3:40 P.M. with Assistant Director of Nursing (ADON) #744 confirmed Resident #8 did not receive the Aspirin 81 mg or Fish Oil oral capsule 500 mg in the morning on 01/14/25 per the physician order. Review of the facility policy titled, Administering Medications, revised April 2019, revealed medications are administered in a safe and timely manner, and as prescribed. Medications are administered in accordance with prescriber orders, including any required time frame. Medications are administered within one hour of their prescribed times unless otherwise specified (for example, before and after meal orders). 2. Record review for Resident #127 revealed an admitted [DATE]. Diagnosis included type two diabetes mellitus with diabetic chronic kidney disease. Review of the Admission Minimum Data Set (MDS) dated [DATE] revealed Resident #127 was cognitively intact. Resident #127 required set up or clean up assist with eating and was dependent for personal hygiene and transfers. Review of the care plan for Resident #127 dated 11/13/24 revealed Resident #127 had a risk for altered fluid balance. Interventions included administering medications as prescribed. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the physician orders for Resident #127 revealed an order dated 11/15/24 for Humalog solution 100 units/milliliter (ml) (Insulin Lispro) Inject as per sliding scale: if the blood sugar was 150 - 200 = two units (u); 201 - 250 = four u; 251 - 300 = six u; 301 - 350 = eight u, 351 - 400 = 10 u, 401 and above give 12 units and notify physician, subcutaneously before meals for diabetes. Review of the orders revealed Resident #127 had an order for a regular diet regular texture dated 11/15/24. Observation on 01/14/25 at 8:44 A.M. revealed Licensed Practical Nurse (LPN) #557 entered Resident #127's room. Resident #127 was sitting up in bed with his breakfast tray in front of him. Resident #127's plate and glasses were empty. Resident #127 revealed he had eggs, hash browns, cereal and juice for breakfast. Observation revealed LPN #557 assessed Resident #127's blood sugar via glucometer. The blood sugar results were 209. Observation revealed LPN #557 administered Humalog solution four units subcutaneously. Interview on 01/15/25 at 11:31 A.M. with Resident #127 revealed sometimes the nurses did not check his blood sugars until after he ate his meal. Interview on 01/14/25 at 9:15 A.M. with LPN #557 confirmed the blood sugar for Resident #127 was assessed after the breakfast meal was completed and insulin was administered for per a sliding scale. LPN #557 revealed sometimes she did assess resident blood sugar after the meal and confirmed it was supposed to be done before meals. Interview on 01/14/25 at 1:47 P.M. with Director of Nursing (DON) confirmed blood sugars were to be assessed prior to meals. Review of Healthline dated 12/08/20 revealed in the sliding scale method, the dose (insulin) is based on your blood sugar level just before your meal. The higher the blood sugar, the more insulin you take. 3. Record review for Resident #271 revealed an admitted [DATE]. Diagnosis included type two diabetes mellitus and need for assistants with personal care. Review of the Admission MDS dated [DATE] revealed Resident #271 was cognitively intact. Resident #271 required substantial/maximal assistants with eating and was dependent for personal hygiene and transfers. Review of the physician orders for Resident #271 revealed an order dated 11/29/24 for Humalog solution 100 units/milliliter (ml) (Insulin Lispro) Inject as per sliding scale: if the blood sugar (BS) was 71 - 150 = 0 units; 151 - 200 = two units (u); 201 - 250 = four u; 251 - 300 = six u; 301 - 350 = eight u, 351 - 400 = 10 u, if BS greater than 400 notify physician, administer subcutaneously before meals for diabetes. Review of the care plan dated 12/11/24 for Resident #271 revealed Resident #271 has diabetes mellitus, insulin usage. Interventions included diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 01/14/25 at 9:01 A.M. revealed LPN #557 entered Resident #271's room. Resident #271 was lying in bed. Resident #271 revealed he already had his breakfast and ate 100%. Observation revealed LPN #557 assessed Resident #271's blood sugar via glucometer. The blood sugar results were 167. Observation revealed LPN #557 administered Humalog solution two units subcutaneously to Resident #271. Interview on 01/14/25 at 9:15 A.M. with LPN #557 confirmed the blood sugar for Resident #271 was assessed after the breakfast meal was completed and insulin was administered for the resident per a sliding scale. LPN #557 revealed sometimes she did assess resident's blood sugar after the meal and confirmed it was supposed to be done before meals. Interview on 01/14/25 at 1:47 P.M. with DON confirmed blood sugars were to be assessed prior to meals. Review of Healthline dated 12/08/20 revealed in the sliding scale method, the dose (insulin) is based on your blood sugar level just before your meal. The higher the blood sugar, the more insulin you take. Review of the facility policy titled, Administering Medications revised April 2019 revealed medications are administered in a safe and timely manner, and as prescribed. Medications are administered in accordance with prescriber orders, including any required time frame. Medications are administered within one hour of their prescribed times unless otherwise specified (for example, before and after meal orders). This deficiency represents non-compliance investigated under Complaint Number OH00161278, OH00161166, and OH00161595.

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	01/16/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42011 Based on observation, interview, record review, review of the label directions on the cleaning wipes and review of the facility policy, the facility failed to ensure proper cleaning of a blood glucose meter while checking resident blood sugar levels. This affected two residents (Resident #127 and #271) and had the potential to affect an additional 28 residents (Resident #5, #31, #36, #46, #49, #51, #58, #61, #81, #85, #92, #116, #124, #145, #148, #152, #163, #186, #195, #230, #242, #245, #254, #261, #272, #273, #275, and #276) who received blood glucose level checks via a glucometer. The facility census was 277. Findings include: 1. Record review for Resident #127 revealed an admitted [DATE]. Diagnosis included type two diabetes mellitus with diabetic chronic kidney disease. Review of the physician orders for Resident #127 revealed an order dated 11/15/24 for Humalog solution 100 units/milliliter (ml) (Insulin Lispro) Inject as per sliding scale before meals for diabetes. Observation on 01/14/25 at 8:44 A.M. of a blood sugar assessment via glucometer revealed Licensed Practical Nurse (LPN) #557 removed the glucometer from the top right hand drawer (lying on the bottom of the drawer uncovered) of the medication cart. Inside the drawer was insulin vial, alcohol wipes, and lancets. LPN #557 did not clean the glucometer. Observation revealed LPN #557 entered Resident #127's room and assessed Resident #127's blood sugar via glucometer. LPN #557 then sat the glucometer directly on Resident #127's nightstand while conversing with Resident #127. LPN #557 then returned to the medication cart and put the glucometer directly back in the top right hand drawer without cleaning the glucometer. 2. Record review for Resident #271 revealed an admitted [DATE]. Diagnosis included type two diabetes mellitus and need for assistants with personal care. Review of the physician orders for Resident #271 revealed an order dated 11/29/24 for Humalog solution 100 units/milliliter (ml) (Insulin Lispro) Inject as per sliding scale subcutaneously before meals for diabetes. Observation on 01/14/25 at 9:01 A.M. of blood sugar assessment via glucometer revealed LPN #557 removed the glucometer (the same glucometer used for Resident #127) from the top right hand drawer of the medication cart. LPN #557 then opened an alcohol wipe and wiped the front of the glucometer only with an alcohol wipe for approximately three to five seconds. LPN #557 then placed the glucometer in a small green basket located on the medication cart, entered Resident #271's room and assessed Resident #271's blood sugar via glucometer. LPN #557 then returned the basket with the glucometer in it to the medication cart, took an alcohol wipe, and cleaned the glucometer front and back with the alcohol wipe for approximately three to five seconds. LPN #557 then placed the glucometer back in the basket then back in the top right-hand drawer of the medication cart. the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 01/14/25 at 9:15 A.M. with LPN #557 confirmed she did not clean the glucometer before or after use for Resident #127 then used an alcohol wipe only to clean the glucometer prior to and after assessing Resident #271's blood sugar via glucometer. LPN #557 confirmed each medication cart had one glucometer to share with the residents receiving medications from that cart. Interview on 01/14/25 at 1:47 P.M. with Director of Nursing (DON) and Assistant Director of Nursing (ADON) #744 revealed per DON glucometer's were to be cleaned between residents. The facility used Super Sani cloth wipes. Per ADON #744 the nurses were to wipe the entire glucometer with the wipe then allow two minutes wet time then do not reuse until completely dry. Review of the label directions on the container of the Super Sani cloth wipes for cleaning hard surfaces including glucometer's on the container of the Super Sani cloth wipes with ADON #744 revealed to thoroughly wet surface. Allow the surface to remain wet two minutes, let air dry. Interview 01/15/24 at 3:40 P.M. with ADON #744 revealed LPN #557 worked all areas of the facility. Review of the facility policy titled, Blood Sampling - Capillary (Finger Sticks) undated revealed the purpose of this procedure is to guide the safe handling of capillary-blood sampling devices to prevent transmission of bloodborne diseases to residents and employees. Always ensure the blood glucose meters intended for reuse are cleaned and disinfected between resident uses with approved germicidal disinfectant and let dry between uses.