

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 02/27/2025
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 0626</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42730</p> <p>Based on closed record review, and interview, the facility failed to ensure Resident #284 was permitted to return to the facility after being transferred to the emergency room due to an acute change in condition. This affected one resident (#284) of one resident reviewed for hospitalization . The facility census was 283.</p> <p>Findings include:</p> <p>Review of the closed medical record for Resident #284 revealed an admitted [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD), peripheral vascular disease, amputation, and atherosclerotic heart disease.</p> <p>Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #284 was alert and oriented to person, place, and time. Review of the MDS assessment revealed Resident #284 was dependent on staff for activities of daily living (ADLs).</p> <p>Review of the care plan dated 02/04/22 revealed Resident #284 was expected to remain in the facility for long-term care placement.</p> <p>Review of the physician's orders dated November 2024 through February 2025 revealed Resident #284 had no discharge orders in place.</p> <p>Review of a progress note dated 11/22/24 at 11:20 A.M. but entered approximately three days later on 11/25/24 at 1:43 P.M., revealed Social Service Designee (SSD) #677 informed Resident #284's daughter via phone of the need to reschedule a care conference that was scheduled for 11/25/24 at 10:30 A.M. During the phone conversation, Resident #284's daughter requested the Director of Nursing (DON), and Assistant Director of Nursing (ADON) not attend the care conference and further inquired if the Administrator would be present, stating that if the Administrator was present, she would not be able to attend the care conference as she had been informed by her lawyer that the Administrator was not to have contact with herself or Resident #284.</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 0626</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the progress note dated 11/26/24 at 2:00 P.M., but entered approximately 15 days later on 12/11/24, revealed SSD #677 presented Resident #284 with a 30-day discharge notice and a copy of the notice was mailed to Resident #284's son. Resident #284 was informed he had a right to file an appeal if he did not agree with the discharge. Resident #284 requested to file an appeal and Resident #284's son filed the appeal. A hearing was scheduled to take place on 12/13/24 at 4:00 P.M.</p> <p>Review of the 30-day discharge notice dated 11/26/24 revealed Resident #284 received a discharge notice to take effect on 12/26/24 due to the welfare and needs of Resident #284 no longer being able to be met by the facility. Further review of the notice verified Resident #284 signed acknowledging the receipt of the notice and Resident #824's son was mailed a copy of the notice.</p> <p>Review of Resident #284's medical record failed to contain documentation of the specific needs that could no longer be met by the facility.</p> <p>Review of the progress note dated 01/17/25 at 10:56 A.M. revealed it was documented that Resident #284 became lethargic and unresponsive while attempting to shower. After vital signs were taken, Resident #284 was placed back in bed and aroused slowly. Orders were received to transfer Resident #284 to the hospital for evaluation.</p> <p>Review of the progress note dated 01/17/25 at 11:33 A.M. revealed Resident #284's daughter was notified of the resident's transport to the acute hospital.</p> <p>Review of the Nursing Home to Hospital Transfer Form assessment dated [DATE] revealed Resident #284 was emergently transferred to the acute hospital due to loss of consciousness (syncope) with a plan to return to the facility. Review of the assessment revealed Resident #284 was a chronic long-term care resident at the time of the transfer to the hospital.</p> <p>Review of the progress notes dated 01/17/25 through 02/26/25 revealed Resident #284 had not returned to the facility.</p> <p>Interview on 02/24/25 at 10:42 A.M. with SSD #677 verified Resident #284 received a 30-day discharge notice on 11/26/24 and Resident #284, his daughter, and son, requested an appeal. SSD #677 revealed Resident #284 won the appeal process and was granted permission to remain in the facility for long-term care. SSD #677 then verified Resident #284 was transferred to the hospital due to a fainting episode and was expected to return to the facility. However, SSD #677 verified Resident #284 had not returned to the facility and was not sure why as the SSD revealed residents who transferred to the hospital were expected to return to the facility after medically cleared</p> <p>(continued on next page)</p>

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<p>F 0626</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 02/24/25 at 10:55 A.M. with the DON verified Resident #284 was sent out to the hospital on 01/17/25 and had not returned to the facility. The DON and was uncertain whether the resident remained in the hospital and was not sure when or if the resident would return to the facility. The DON verified Resident #284 received a 30-day discharge notice in November 2024, but could not recall for what reasons. The DON revealed the Administrator was responsible for all decisions regarding Resident #284, including the 30-day discharge notice being given in November 2024 and the decision to not allow Resident #284 to return to the facility on [DATE] (when he returned to the building). In a follow-up interview with the DON, she denied knowledge of Resident #284 returning to the facility on [DATE] after being medically cleared at the hospital, but denied entry into the building. The DON was unable to answer if Resident #284 was provided 30-day discharge notice when denied re-entry on 01/17/25.</p> <p>Interview on 02/24/25 at 11:06 A.M. with Admissions Director (AD) #679 revealed she was responsible for all facility admissions, including the re-admission of residents returning to the facility after a hospitalization . AD #679 revealed that once the hospital informed her that Resident #284 was ready to return to the facility on [DATE], she sent the call to the Administrator as directed by the Administrator. AD #679 stated she was informed by the Administrator that Resident #284 would not return to the facility due to the facility not being able to manage Resident #284's care.</p> <p>On 02/24/25 at 12:00 P.M. an attempted interview with the Administrator regarding Resident #284 revealed he vaguely remembered Resident #284 and would have to return to complete the interview once he reviewed his notes in regard to the resident.</p> <p>A follow-up interview on 02/24/25 at 4:40 P.M. with the Administrator revealed Resident #284 did not return to the facility after evaluation for the syncopal episode on 01/17/25, due to the facility being unable to meet the resident's needs. The Administrator was unsure why the facility could no longer meet Resident #284 needs, stating he asked nursing about the resident returning and was told the facility could not meet Resident #284's care needs. The Administrator acknowledged Resident #284 had been a resident since 2022 and confirmed Resident #284 transferred to the hospital on 01/17/25 but had not been permitted to return as of this date. In a follow up interview, the Administrator denied knowledge of Resident #284 attempting to return (on 01/17/25) to the facility and being denied entry and was unable to verify if a 30-day notice had been provided to Resident #284 on or after 01/17/25.</p> <p>Interview on 02/25/25 at 9:21 A.M. with Licensed Practical Nurse (LPN) #714 revealed Resident #284 was appropriate to be long-term care in the facility. LPN #714 revealed Resident #284 did not display any behaviors, required some assistance from staff, and did not have any complaints regarding care. LPN #714 had expected Resident #284 to return after his hospitalization (on 01/17/25).</p> <p>Interview on 02/25/25 at 9:24 A.M. with Certified Nursing Assistant (CNA) #500 revealed Resident #284 was appropriate to be a resident in the facility. CNA #500 revealed Resident #284 did not require any more care than any other resident residing in the facility. CNA #500 revealed Resident #284 required some assistance for toileting and could maneuver by himself. CNA #284 revealed Resident #284 was also very cognitively aware.</p> <p>(continued on next page)</p>		

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<p>F 0626</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 02/25/25 at 9:58 A.M. with LPN #794 revealed Resident #284 was a total care for ADLs and required some assistance from staff for other needs, like having water set-up in his room. LPN #794 stated Resident #284, whether totally dependent or not, was an appropriate resident for the facility, as there were other residents residing in the facility who required more hands-on care.</p> <p>Interviews with Resident #284's family throughout the survey process revealed the family had placed a camera in Resident #284's room and when there were care concerns, lack of staff response to the call light or when medications were not administered timely the daughter would call and talk with nurse. The daughter of Resident #284 stated on 01/17/25 she was notified by the facility of Resident #284 having a syncopal episode while in the shower and that Resident #284 was being transported to the hospital per private ambulance. The daughter questioned why by private ambulance and not emergency services and was not provided with an answer. Additionally, the daughter requested Resident #284 not be sent to the hospital the facility had identified he was being transported to. The daughter stated she again inquired why the resident was not going to a hospital closer to the facility, as there were two, due to the emergency situation and again was not provided an answer. The daughter stated she received a call from the hospital around 3:30 P.M. on 01/17/25 informing her Resident #284 had been medically cleared and was being returned to the facility per private ambulance. The family met Resident #284 and the ambulance at the facility. The daughter stated both Resident #284 and the family were denied entry into facility and were told they were not welcome back as the family was too much trouble. The daughter stated the family requested to obtain Resident #284's dentures and phone from his room and again were denied access. Police were called and with a police escort one family member was able to obtain Resident #284's dentures and phone from the resident's room. The daughter continued, since Resident #284 was not able to return to facility he had to be transported to another hospital, which was full and unable to accept Resident #284 as he did not have an emergency condition, so he was then sent to another hospital where he remained until 01/24/25. The daughter stated family was unable to care for Resident #284 at home and needed to find safe alternate placement.</p> <p>(continued on next page)</p>		

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<p>F 0626</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview during the survey process with the hospital Care Transition Manager (CTM) where the resident was ultimately admitted on [DATE] revealed Resident #284 was admitted on [DATE] and discharged on [DATE]. The CTM stated the hospital had no choice but to keep Resident #284 as the resident did not have a safe place to discharge to (when the nursing home refused to allow him to return). The CTM stated upon arrival to the emergency department on 01/17/25, Resident #284 shared he had been at another hospital earlier in the day due to an altered level of consciousness, after a work-up he was discharged and upon returning to the facility where has lived since 2022, was denied entry. The CTM stated they called the facility and was told Resident #284 could not return, with no other explanation provided. In a conference call on 01/20/25 at 4:30 P.M. with the facility Administrator, the CTM stated she could not get confirmation as to why Resident #284 was not permitted to return to the facility and further could not get confirmation of Resident #284 being provided with the required 30-day notice. The CTM stated the Administrator had a 'canned' dissertation about Resident #284's family. The CTM stated after three attempts of explaining the requirement of the 30-day notice and informing the Administrator that Resident #284's return could not be refused, she stated she gave up because the Administrator only provided a repeat of the canned dissertation and never answered her question, if a 30-day discharge notice had been provided. The CTM stated she assumed no notice had not been provided, at which time the CTM stated hospital staff started to send referrals to other facilities, with a total of 22 referrals sent. The CTM stated finding placement for Resident #284 was a challenge as they received several denials due to the referring facilities reaching out to the facility Resident #284 had resided and being told horrible things about the resident's family. The CTM stated the resident was accepted by a facility within a close proximity from the original facility on 01/24/25 at 1:14 P.M. and was discharged .</p> <p>A request was made to review any policy and procedures related to discharge; however, as of 02/27/25 at the completion of the survey, no policy had been provided to review. During the complaint survey, the DON had indicated the facility was willing to take the cite over dealing with the resident's family. The DON had stated, We already figured we were getting that cite.</p> <p>This deficiency represents non-compliance investigated under Complaint Numbers OH00161872, OH00161814, OH00161818, and OH00161828.</p>		