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	09/22/2025

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365094	A. Building B. Wing	09/22/2025

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, interview and review of the facility policy, the facility failed to ensure residents dependent on staff for activities of daily living (ADL) received assistance for feeding and showers as ordered, recommended per therapy and/or per preference. This affected two residents (#8 and #195) out of four residents reviewed for resident's dependent on ADL care on the [NAME] unit. This had the potential to affect four residents (#91, #107, #185, and #195) that required feeding assistance, and all 31 residents (#8, #33, #45, #61, #89, #91, #93, #102, #104, #107, #143, #146, #155, #181, #185, #187, #192, #194, #195, #198, #199, #200, #203, #213, #229, #231, #233, #249, #252, #267, and #292) that the facility identified requiring assistance with showers on the [NAME] unit. The facility census was 259. Findings include: 1. Review of the medical record for Resident #195 revealed an admission date of 02/01/10 with diagnoses including hemiplegia affecting the right dominant side, dysphagia, diabetes, and gastro-esophageal reflux disease (GERD). Review of the care plan dated 02/14/20 revealed Resident #195 had a self-care performance deficit. Interventions included assistance of one staff with eating. Review of the care plan dated 02/14/20 revealed Resident #195 required assistance with ADL including cues and assistance with feeding as needed to assist in choking prevention. Interventions included cueing the resident and/or assisting with feeding and reminding the resident to slow down when feeding self. Review of the undated Assignment B report sheet revealed Resident #195 was not to have coffee, was on a soft diet with honey thick liquids, no cold cereal, encourage oral fluids, and head of bed up at 45 degrees at all times. Review of the nursing notes dated 06/11/25 at 8:47 A.M. and authored by Registered Nurse (RN) #958 revealed Resident #195 choked on scrambled eggs. Nurses and Certified Nursing Assistants (CNAs) were able to dislodge the food, as Resident #195 was lowered to the floor. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #195 had intact cognition and had impairment of one of her upper extremities. She required set up and clean up assistance with eating. She was on a mechanically altered diet. Review of the Speech Therapy Updated Therapy Plan dated 08/22/25 and completed by Speech Therapist (ST) #712 revealed Resident #195 had dysphagia and hemiplegia of her right dominant side. She had a choking incident on 06/11/25 and required cues to reduce rate and alternate liquids and solids. She had precautions in place that included instructing the resident to double swallow, no hot liquids and soft texture diet. Review of the September 2025 physician orders revealed Resident #195 had an order for mechanical soft, diabetic diet with nectar thickened liquids and an order dated 06/12/25 for Resident #195 to be fed by staff, including to sit with the resident, and remind the resident to slow down and chew her food thoroughly before attempting to swallow every shift. Observation on 09/10/25 at 8:15 A.M. revealed Resident #195 was eating breakfast in the dining room with her tray in front of her. She was eating scrambled eggs, banana, and hot cereal independently. She appeared to place large bites into her mouth utilizing a foam handled spoon and taking another bite before fully swallowing the previous bite. She had an occasional cough while eating and drinking. CNA #506 was observed in the dining room with her back to Resident #195 feeding Resident #185 and was not reminding Resident #195 to slow down and chew her food thoroughly before attempting to swallow. Interview on 09/10/25 at 8:30 A.M. with CNA #506 revealed she was told that Resident #195 ate by herself and did not require any assistance, including feeding, monitoring, cueing, reminding the resident to slow down, and/or to chew her food thoroughly before attempting to swallow. She was not aware of any previous choking incidents and was not aware of any feeding interventions. Observation on 09/10/25 at 12:25 P.M. revealed Resident #195 received her tray from CNA #656 in the dining room. He uncovered her tray which included an enchilada, diced carrots, rice and pears and then went back to pass other trays. Resident #195 picked up the enchilada and began to take a bite, chewed once and then took another bite. Resident #195 continued to take multiple bites at a fast pace without fully chewing and swallowing the food. After completing the enchilada, she picked up her spoon with foam handle and began scooping a heaping spoonful of rice and carrots placing it in her mouth. Before she completely chewed and swallowed, she consumed another heaping spoonful. She continued to repeat the process until she completed the rice and carrots. She then took the fruit cup lifted the cup to her mouth and took one large gulp of juice and fruit (pears) and before fully chewing and swallowing she repeated and took a second gulp (emptying the fruit cup) in the two gulps. During the process, Resident #195 coughed intermittently, and no staff intervened attempting to feed, remind Resident #195 to slow down and chew her food thoroughly before

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	09/22/2025

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation and interview, the facility failed to ensure Resident #201 was offered activities to meet her preferences. This affected one resident (#201) of three residents reviewed for activities. The facility census was 259. Findings include:Review of the medical record for Resident #201 revealed an admission date of 07/19/23. Diagnoses included Alzheimer's disease, congestive heart failure, glaucoma, kidney disease and anxiety. Review of the comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #201 was severely cognitively impaired. She required setup help for eating, and supervision for oral hygiene, toileting dressing, showering and hygiene. It was very important to her to have books, newspapers and magazines to read, listen to music that she liked, be around animals, keep up with the news, do things with groups of people, get fresh air outside and participate in religious services or practices. Review of the care plan dated 07/25/25 revealed Resident #201 would benefit from activities such as walking groups, discussions, keeping up with the news, ice cream socials, religious services and being outdoors. Interventions included assisting her with the television (TV) as needed, encouraging her to attend scheduled outdoor programming and religious activities, attending scheduled activities during the week such as music and special events and accepting room visits from life enrichment staff. Review of the activity calendar for July, August and September 2025 revealed no activities listed for the locked dementia unit where Resident #201 resided. Review of the activity participation note dated 08/26/25 revealed resident #201 enjoyed being social with others and liked to participate in activities such as music, art and games. Interview on 09/08/25 at 1:43 P.M. with Resident #201's granddaughter/guardian revealed the resident was often alone in her room when she came to visit. She would encourage her grandmother to leave her room while she was there, which the resident did willingly. Observation on 09/10/25 at 12:50 P.M. revealed Resident #201 was sitting at the end of the hallway holding a toy doll, she was pleasant and alert. She was not involved in actives. Observation on 09/11/25 at 1:53 P.M. revealed Resident #201 was sitting by herself at the end of the hallway. She was not involved in activities. Observations of the locked dementia unit on 09/08/25, 09/09/25, 09/10/25, 09/11/25, 09/15/25 and 09/16/25 revealed no formal activities on the locked dementia unit. Review of the document titled Record of One-on-One Activities dated 08/04/25 through 09/12/25 revealed Resident #201 participated in music therapy six times and received a visit from activity staff eight times. She was described as chatty, talking, singing and dancing at various intervals throughout the events. Interview on 09/16/25 at 1:18 P.M. with Activity Director #845 revealed activities such as hand massages, music, walking and activity carts were available for residents on the locked unit where Resident #201 resided. She revealed Resident #201 participated in approximately one group activity in the past few weeks and did not normally attend group activities. She confirmed activity staff did not remind residents on the unit when a group activity was taking place or encourage participation. She also confirmed there were multiple activities that occurred outside of the locked unit; however, staff availability did not always afford the option for residents on the locked dementia unit where Resident #201 resided to attend those events. She acknowledged Resident #201 had an interest in activities such as music, animals, keeping up with the news, being with groups of people and other social events but could provide no additional evidence that those activities had been provided to or offered to Resident #201. She confirmed the activity calendar for July, August and September 2025 did not identify specific activities that would occur on the locked dementia unit where Resident #201 resided. This deficiency represents noncompliance investigated under Complaint Number 1383336 (OH00165819).

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	09/22/2025

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 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** Based on record review and interview, the facility failed to ensure a change in condition was thoroughly addressed and vital signs were obtained as ordered. This affected two residents (#93 and #278) of three residents reviewed for change in condition. The facility census was 259. Findings include:1. Review of the medical record for Resident #278 revealed an admission date of [DATE] and expired on [DATE] (. Diagnoses included malnutrition, diabetes, spinal stenosis, high cholesterol and dementia. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #278 was severely cognitively impaired. She required setup help for eating, substantial or maximum assistance for oral care and was dependent on staff for toileting, showering and personal hygiene. Review of the physician's orders for [DATE] revealed an order for a Do Not Resuscitate Comfort Care Only Arrest (DNRCCA) (order that allows patients to receive all standard medical treatments, including resuscitation, until a cardiac or respiratory arrest occurs). Review of the nursing progress note dated [DATE] at 5:17 P.M. revealed Licensed Practical Nurse (LPN) #865 was notified by an unidentified certified nursing assistant (CNA) that Resident #278 was vomiting. LPN #865 assessed the resident who had yellow feces all over her with no smell. The nurse practitioner (NP) was notified and gave orders for a KUB (x-ray of the kidneys, ureter and bladder), chest X-ray and CBC (complete blood count), BMP (basic metabolic panel) and MA (magnesium level), STAT (immediately). Review of the nursing progress note dated [DATE] at 7:28 P.M. revealed a stool sample was needed to rule out Clostridioides difficile (C, Diff) (a bacterium that can cause severe diarrhea and other gastrointestinal problems). Her temperature was reported as 97.8 degrees Fahrenheit (F). Review of the KUB and chest x-ray results dated [DATE] at 8:22 P.M. revealed no obstructive bowel gas pattern and no acute abnormalities. Interview on [DATE] at 9:24 A.M. with LPN #981 confirmed the CBC, BMP, MA and stool sample order for Resident #278 was never obtained. She confirmed Resident #278 was identified as having a change in condition, which was not fully addressed. Interview on [DATE] at 9:51 A.M. with LPN #865 revealed she identified a change in condition for Resident #278 and notified the NP who ordered a KUB, chest X-ray and STAT labs. She assessed the color of Resident #278's vomit, and took her blood pressure and temperature, but confirmed they were not documented in the resident's medical record. She could not verify a formal assessment had been documented. Interview on [DATE] at 10:30 A.M. with LPN #644 revealed Resident #278 had been declining for a while prior to her change in condition. She was consuming Boost (nutritional supplement) as ordered and taking an appropriate amount of fluids. Interview on [DATE] at 10:36 A.M. with LPN #984 revealed Resident #278 appeared to be at baseline in the days prior to her expiring. She could not recall if any additional labs are treatments were ordered or in place for her. (continued on next page)

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	09/22/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview one [DATE] at 10:40 A.M with LPN #798 revealed Resident #278 was at baseline in the days prior to her expiring. She could not confirm her stool sample had been completed but stated it would have been documented if it had been done. She revealed Resident #278 had loose stools when she called the physician, and he ordered the labs and KUB. Interview on [DATE] at 10:44 A.M. with LPN #663 revealed she observed no vomiting or diarrhea for Resident #278 in the days prior to her expiring. She revealed she was at baseline. On [DATE] at 10:50 A.M. a phone call made to Resident #278's NP #507 that was not returned. Interview on [DATE] at 11:08 A.M. with LPN #679 revealed she spoke with the physician and Resident #278's family. She revealed that residents' son was on-site when she expired. Resident #278 was last seen at approximately 2:00 P.M. and was doing well. She had no knowledge of Resident #278 not feeling well. Review of the facility policy titled “Resident Change in Condition Policy,” dated [DATE], revealed the nurse would address any emergent situation and gather information such as current vital signs including blood pressure, temperature, pulse, respirations and pulse ox and provide the information to the physician. Information related to the change in condition and subsequent events and notifications would be documented in the residents' medical record. 2. Review of the medical record for Resident #93 revealed an admission date of [DATE] with diagnoses including congestive heart failure (CHF), hypertension, acute kidney failure, acute and chronic respiratory failure with hypoxia, and history of myocardial infarction. Review of the [DATE] physician orders revealed Resident #93 had an order dated [DATE] for vital signs vitals every four hours (four times a day) for CHF. Review of the Treatment Administration Record (TAR) for [DATE] and [DATE] revealed Resident #93 was to have vitals every four hours (four times a day) for CHF. The TAR revealed the nurse signed off at 9:00 A.M., 1:00 P.M., 5:00 P.M. and 9:00 P.M. that vitals were obtained but there were no specific vital signs documented as ordered on the TAR. Review of the “Pulse Summary” in the electronic monitoring system from [DATE] to [DATE] revealed Resident #93's pulse rates: [DATE] at 9:38 A.M. his pulse rate was 60 beats per minute, [DATE] at 9:19 A.M. his pulse rate was 59 beats per minute, [DATE] at 12:45 P.M. his pulse rate was 63 beats per minute, [DATE] at 5:14 P.M. his pulse rate was 62 beats per minute, [DATE] at 10:05 A.M. his pulse rate was 62 beats per minute, [DATE] at 3:34 A.M. his pulse rate was 69 beats per minute, and on [DATE] at 10:12 A.M. his pulse rate was 78 beats per minute. (There was no documented evidence that his pulse was assessed as ordered). Review of the “Respiration Summary” in the electronic monitoring system from [DATE] to [DATE] revealed Resident #93's respiratory rates: [DATE] at 9:38 A.M. his respirations were 18 per minute, [DATE] at 9:19 A.M. his respirations were 17 per minute, [DATE] at 12:45 P.M. his respirations were 17 per minute, [DATE] at 5:14 P.M. his respirations were 16 per minute, [DATE] at 10:05 A.M. at his respirations were 16 per minute, [DATE] at 3:34 A.M. his respirations were 18 per minute, [DATE] at 10:12 A.M. his respirations were 18 per minute, and [DATE] at 11:06 P.M. his respirations were 18 per minute. (There was no documented evidence that his respirations were assessed as ordered). (continued on next page)

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	09/22/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the “Temperature Summary” in the electronic monitoring system from [DATE] to [DATE] revealed Resident #93's temperature: [DATE] at 9:38 A.M. his temperature was 97.7 degrees Fahrenheit (F), [DATE] at 9:19 A.M. his temperature was 98.4 degrees F, [DATE] at 12:45 P.M. his temperature was 97.5 degrees F, [DATE] at 5:14 P.M. his temperature was 98.2 degrees F, [DATE] at 10:05 A.M. his temperature was 98.2 degrees F, [DATE] at 3:34 A.M. his temperature was 96 degrees F, [DATE] at 10:12 A.M. his temperature was 98 degrees F and [DATE] at 11:06 P.M. his temperature was 98.7 degrees F. (There was no documented evidence that his temperature was assessed as ordered). Review of the “Blood Pressure Summary” in the electronic monitoring system from [DATE] to [DATE] revealed Resident #93's blood pressure was obtained: [DATE] at 12:09 A.M., 9:38 A.M. and 10:54 P. M., [DATE] at 11:49 A.M., [DATE] at 9:14 P.M., [DATE] at 9:19 A.M.,12:45 P.M., 5:14 P.M., 8:47 P.M., [DATE] at 9:17 A.M., 8:56 P.M., [DATE] at 10:05 A.M., [DATE] at 1:12 P.M., 9:37 P.M., [DATE] at 8:00 A.M., 10:42 A.M., [DATE] at 1:12 P.M., 10:08 P.M., [DATE] at 9:40 A.M., 10:46 P.M., [DATE] at 9:13 A.M., 1:30 P. M., 8:34 P.M., [DATE] at 8:14 A.M., 10:14 P.M., [DATE] at 3:34 A.M., 8:15 A.M., 3:19 P.M, 9:49 P.M., [DATE] at 8:03 A.M. 8:42 P.M., [DATE] at 10:02 A.M., [DATE] at 8:06 A.M., 11:49 P.M., [DATE] at 8:33 A.M., 3:06 P.M., 8:35 P.M., [DATE] at 5:06 A.M., 1:06 P.M., 11:31 P.M., [DATE] at 3:27 P.M., 10:57 P.M., [DATE] at 8:37 A.M., 11:43 P.M., [DATE] at 10:37 A.M., 10:49 P.M., [DATE] at 8:06 A.M. 1:17 P.M., [DATE] at 8:09 A.M., 1:05 P.M., 10:17 P.M., [DATE] at 8:04 A.M., 1:07 P.M., 10:08 P.M., [DATE] at 8:11 A.M., 1:01 P.M., 10:03 P.M., [DATE] at 10:56 A.M., [DATE] at 8:35 A.M., 1:14 P.M., [DATE] at 12:00 A.M., 1:35 P.M., [DATE] at 9:54 A.M., [DATE] at 8:01 A.M., 1:07 P.M., 10:43 P.M., [DATE] at 8:02 A.M., 1:42 P.M., 10:58 P.M., [DATE] at 8:04 A.M., 1:03 P.M., 10:34 P.M., [DATE] at 8:04 A.M., 10:58 P.M., [DATE] at 9:37 A.M., 1:08 P.M. , 10:36 P.M., 11:31 P.M., [DATE] at 8:09 A.M. 1:09 P.M., [DATE] at 8:02 A.M., 1:33 P.M., [DATE] at 8:42 A. M., 1:11 P.M. 8:35 P.M., [DATE] at 8:49 A.M., 1:16 P.M., 11:12 P.M., [DATE] at 8:02 A.M., 1:00 P.M., 11:27 P.M. and [DATE] at 9:00 A.M. His blood pressure varied during this time frame as his blood pressure ranged from 103/61 to 200/108. There was no blood pressure documented on [DATE], and [DATE]. (There was no documented evidence that his blood pressure was assessed as ordered). Interview on [DATE] at 1:58 P.M. with the Director of Nursing (DON) verified Resident #93 had an order dated [DATE] that read the following: vitals every four hours (four times a day) for CHF. She verified that the nurse was just initialing on the TAR and that there was no documented evidence that vital signs were obtained as ordered. She verified vital signs including blood pressure, pulses, respirations, and temperatures were not assessed as ordered. She revealed she did not have a policy in regard to obtaining vital signs and the documentation of. This deficiency represents non-compliance investigated under Complaint Numbers 2601023.

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	09/22/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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	09/22/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, interview and facility policy review, the facility failed to ensure fall interventions were in place and falls were thoroughly investigated. This affected one resident (Resident #259) of three reviewed for falls and orders. The facility census was 259. Findings include:Review of the medical record for Resident #259 revealed an admission date of 09/27/24. Diagnoses included muscle weakness, artificial hip joints, dementia, depression and glaucoma. Review of the care plan initiated 10/09/24 revealed Resident #259 was at risk for falls. Interventions included anticipating the resident's needs, anticipating safety needs and potential hazards, assessing proper footwear and suggesting change if needed, ensuring the resident's call light is within reach and encouraging the resident to use it to call for assistance. A new intervention was added on 11/11/24 to lay the resident down after meals. Review of the care plan dated 10/16/24 revealed Resident #259 had an actual fall. Interventions included providing one-on-one activities that promote exercise and strength where possible, provide one-on-one activities if bedbound, physical therapy (PT) consult for strength and mobility, ensuring the call light was within reach, encouraging the resident to use the call light for any transfers, ensuring the resident has non-skid socks or proper shoes for transfers, and encouraging the resident to go to the dining room for dinner. New interventions were added lay the resident down after lunch (11/10/24), pain medication regimen (11/19/24), keep the bathroom light on at night as tolerated by the resident (11/25/24), bed in low position (12/09/25), and a bolster mattress (03/22/25). Review of the fall risk assessment dated [DATE] revealed Resident #259 was at risk for falls. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #259 had severe cognitive impairment and required partial to moderate assistance for lower body dressing, hygiene, sit-to-stand, chair/bed-to-chair transfers and toilet transfers. The resident required substantial to maximum assistance for toileting hygiene and showers. Resident #259 was occasionally incontinent of bowel and bladder. Review of the fall investigation dated 07/24/25 at 1:20 P.M. revealed Resident #259 was oriented to himself and sustained an abrasion to his left hip. Witness statements were obtained by staff, and the nurse practitioner (NP), family and nursing supervisor were notified. A toileting program was implemented as an immediate intervention. There was no evidence that the residents' vital signs were assessed, or a full body assessment was completed. In addition, there was no mention of whether appropriate footwear was in place at the time of the fall. Review of the progress note dated 07/24/25 at 3:28 P.M. revealed Resident #259 was found on the floor in his room. (This is the progress note for the fall investigation above). He was lying on his right side, he denied hitting his head. He stated he was on his way to the bathroom and complained of left hip pain. The NP was notified and ordered bilateral STAT (immediate) hip x-rays. Resident #259's guardian and sister were notified; the resident was given Tylenol (analgesic) for pain and neurological checks were initiated. The x-ray revealed a left femur fracture, and Resident #295 was sent to the local emergency department (ED). Review of the fall investigation dated 08/02/25 at 10:30 A.M. revealed Resident #259 was oriented to himself and sustained no injuries. Witness statements were obtained by staff, and the nurse supervisor, family and physician were notified. The resident's vital signs were obtained, and his blood pressure was 131/62, heart rate 79, temperature 98 degrees Fahrenheit (F), respirations 18 and pulse ox 96%. He reported his back pain at a six on a one to 10 scale with 10 being the worst. He was described as confused and incontinent at the time; the physician ordered an x-ray of the back and left hip. There was no documented evidence of the bolster mattress being in place, the call light being in reach, when the resident was last toileted, nonskid socks being in use or the bed being in the lowest position. Review of the progress note dated 08/02/25 at 1:41 P.M. (this is the progress note for the fall investigation above) revealed Resident #259 was found on the floor in his room between his bed and bedside table. His head was at the foot of his bed, and his feet were at the top of the bed. Resident #259 was lying on his back with his wheelchair behind him facing the window. The resident was wrapped in his sheets and complained of back pain. No injuries were noted, his vital signs were blood pressure 131/62 heart rate 98 temperature 96 degrees F, respirations 18. The resident was placed back into bed, and his family and the supervisor were notified. Review of the significant change MDS 3.0 assessment dated [DATE] revealed Resident #259 was severely cognitively impaired and required set-up help for eating, partial to moderate assistance for oral hygiene, chair/bed-to-chair transfers, and toilet transfers. He required substantial to maximum assistance for toileting, personal hygiene and showering. He was frequently incontinent of bowel and bladder. Observation on

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	09/22/2025

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. (continued on next page)

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	09/22/2025

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on interview and record review the facility failed to ensure Resident #7 was provided with reliable transportation to and from dialysis. This affected one resident (#7) of two residents reviewed for transportation. The facility census was 295. Findings include:Review of the medical record for Resident #7 revealed an admission date of 12/27/24. Diagnoses included fracture of the left fibula, acute pain due to trauma, diabetes with diabetic neuropathy, and dependence on renal dialysis. Review of physician order dated 12/28/24 revealed Resident #7 received dialysis on Tuesday, Thursday, and Saturday. The resident must be in the lobby at 9:00 A.M. for pick-up. Review of the admission Minimum Data Set (MDS) 3.0 assessment for Resident #7 dated 01/08/25 revealed the resident was cognitively intact. Resident #7 used a walker and a wheelchair. Transfers were not attempted due to medical condition. Review of the plan of care dated 01/23/25 revealed Resident #7 was at risk for potential complications of dialysis related to end stage renal disease (ESRD) and received dialysis at CDC Fresenius on Tuesday, Thursday, and Saturday. The plan of care specified King [NAME] provided transportation. Review of the nursing progress note dated 02/25/25 at 1:32 P.M. Resident #7 missed the scheduled dialysis chair time related to transportation. The resident stated she did not have transportation. This nurse informed dialysis, and dialysis was rescheduled for Wednesday, 02/26/25 at 1:00 P.M. The resident was aware, and the physician ordered a cardiac assessment. Vital signs were obtained, and the resident was asymptomatic at this time. Review of nursing progress note dated 03/03/25 at 11:40 A.M. revealed the nurse received a phone call from the hospital informing the facility nurse of Resident #7's upcoming appointment on 03/07/25 at 8:00 A.M. related to dialysis catheter port replacement. The hospital nurse inquired about transportation. The facility nurse informed her that Resident #7 was responsible for providing transportation. The facility nurse reiterated to Resident #7 that she was responsible for setting up transportation. Resident #7 was provided with second copy of transportation companies. Review of the Pre/Post Dialysis Evaluations noted Resident #7 was transported to and from dialysis via a private car on 03/08/25, 03/11/25, 03/20/25, 03/22/25, 03/29/25, 04/03/25, 04/08/25, and 04/12/25. Interview on 9/10/25 at 9:20 A.M. with Resident #7 revealed when the Resident first arrived at the facility, she missed dialysis two or three times because she had no one to take her. The facility to the resident she had to find her own transportation. For Para transport, she had to wait for the application to go through and she didn't have money for Uber. The resident stated she was still in a wheelchair, and Uber and Lift were not supposed to have to get out of their car to assist. Later, the facility started taking the resident to her dialysis appointments. The Unit Manager usually arranged the transportation with the transportation office. The transportation department and transporters were very good and treated her well. Interview on 09/16/25 at 2:20 P.M. with Regional Nurse Director #672 revealed she had been at the facility about five months. She stated she didn't know what the transportation set up was previously but knew the facility had used some different transportation companies and there had been concerns with consistent transportation for residents. The facility has been working on correcting transportation issues. The facility had implemented several major changes in how they did resident transportation in May 2025 and felt the issue was corrected. Review of the Transportation Policy dated 09/11/24 revealed the facility will arrange transportation to and from medically necessary appointments and assist with arranging transportation to and from social events. Procedure: Facility will ensure residents receive facility transportation to medically necessary appointments with in-house transportation. The deficient practice was corrected on 05/13/25 when the facility implemented the following corrective actions: By 05/01/25, all facility staff and residents were educated by Regional Nurse Director #672 using in-services and signs hanging on the units of the facility providing transportation to outside medical appointments when necessary either by the facility or insurance related transport. On 05/01/25, all unit managers were educated by Regional Nurse Director #672 on the process of ensuring residents' appointments and transportation needs were given to the transportation scheduler. On 05/13/25, Regional Nurse Director #672 and Previous Administrator #510 met with all the facilities and created the workflow schedule of the drivers to understand schedule availability. On 05/13/25, Previous Administrator #510 educated the transportation coordinators to work together on the scheduling of appointments. On 05/13/25, Regional Nurse Director #672 educated the drivers and transportation coordinators that the

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	09/22/2025

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, test tray and interviews, the facility failed to ensure meals were served at a safe and palatable temperature. This had the potential to affect all residents who received meals from the facility except for six residents (#1, #2, #101, #212, #240, and #261) identified by the facility as having orders for nothing by mouth (NPO). The facility census was 259. Findings include:Interview on 09/08/25 at 11:17 A.M. Resident #58 stated there was no good help in the kitchen. The food in the kitchen is strictly kosher, and she is not getting enough food. She stated sometimes the food is cold because there were not enough staff. By the time she gets her food, it's cold. She also stated the food comes from the kitchen late and it's not good. Interview on 09/08/25 at 12:28 P.M. Resident #192 stated the food is bad, and she cannot eat it. Interview on 09/08/25 at 3:54 P.M. Resident #272 stated the food is gross, cold, and not cooked properly. Interview on 09/09/25 at 8:29 A.M. Resident #54 stated the food was okay, but not seasoned. Interview on 09/11/25 at 8:32 A.M. with Certified Nursing Assistant (CNA) #708 stated she hears a lot of residents complain about the food. They say they get small amounts of food and have to pay for food at the cafe. Interview on 09/11/25 t 8:34 A.M. with Licensed Practical Nurse (LPN) #693 stated she hears a lot of food complaints from the residents. They have to go to the cafe and buy food because they do not like the food or they receive a small amount and are still hungry. Observation on 09/11/25 at 11:20 A.M. revealed the Interim Certified Dietary Manager (CDM) #508 was taking food temperatures for lunch from the steam table in the kitchen. The eggplant cheese lasagna was 174 degrees Fahrenheit (F), the eggplant cheese lasagna with no tomato sauce was 151 degrees F, the veggie patty was 137 degrees F, the Italian green beans were 162 degrees F, and the puree Italian green beans were 134 degrees F. The veggie patties were pulled from the tray line and heated to 160 degrees F. The pureed green beans were pulled from the line and heated to 170 degrees F. Meals were plated and placed on the meal cart to be taken to the unit. No thermal plate liners were used. On 09/11/25 at 11:41 A.M. a test tray was placed on the meal cart. At 11:47 A.M. the meal cart arrived at the Fairmount Pavilion, and the trays were immediately passed to the residents. At 11:58 A.M. all residents had been served their lunch. At 11:59 A.M. the food on the test tray was tasted by the surveyor and CDM #509, with Interim CDM #508 taking the temperatures. The eggplant cheese lasagna was 138 degrees F, the eggplant cheese lasagna with no tomato sauce was 123 degrees F, and the green beans were 121 degrees F. Interview with Interim CDM #508 verified the food temperatures of the eggplant lasagna with no tomato sauce, and the green beans were not at an acceptable service temperature for palatability at the time of the test tray. This deficiency represents non-compliance investigated under Complaint Number 2591287, 2562355, 1383326 (OH00163396) and 1383324 (OH00163342).