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	10/15/2025

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 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. (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

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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 0678 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 closed record review, review of emergency medical services (EMS) run report, review of a facility incident report, staff interviews, and facility policy review, the facility to ensure cardiopulmonary resuscitation (CPR) was initiated immediately and performed appropriately following Resident #271, a resident with a Full code status (indication for healthcare providers to perform all possible life saving measures in the event of a cardiac or respiratory arrest) was found unresponsive. This affected one resident (#271) of three residents reviewed for advance directives. The facility identified 178 residents who had an advance directive of a full code. The facility census was 270.Findings include:Review of the closed medical record for Resident #271 revealed an admission date of 09/25/25 and a date of death of [DATE]. Diagnoses included but were not limited to unspecified convulsion, traumatic subdural hemorrhage without loss of consciousness, end stage renal disease, dependence upon renal dialysis, adult failure to thrive, metabolic encephalopathy, dementia without behaviors, severe sepsis without septic shock, pneumonitis due to inhalation of food and vomit. Resident code status was noted to be full code.Review of the five-day Minimum Data Set (MDS) 3.0 assessment for Resident #271 dated 09/26/25 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 3 which indicated severely impaired cognition. Resident #271 was noted to be dependent on staff for eating, dressing, bathing, and toileting. Resident #271 required maximum assistance from staff for chair transfers and to move from sitting to lying position. Review of a physician visit note dated 09/27/25 at 12:26 P.M. revealed Resident #271 was a [AGE] year-old frail, elderly male resident. The note listed Resident #271's condition as guarded due to multiple medical conditions.Review of a nursing progress note dated 09/27/25 at 8:50 P.M. revealed Registered Nurse (RN) #514 notified Unit Manager #516 that Resident #271 was unresponsive. Unit Manager #516 and another nurse immediately went to the unit and noted Resident #271 without a pulse, respiration, or blood pressure. Resident #271 was noted to be cool to the touch. Chest compressions were started immediately, and nine-one-one (911) was called. Following the arrival of emergency medical services (EMS), the resident was pronounced deceased at 9:10 P.M.Review of a local Fire Department run report dated 09/27/25 at 8:55 P.M. revealed dispatch was notified EMS was needed and EMS personnel arrived on site at the facility at 9:02 P.M. for a non-responsive and non-breathing male. The report noted facility staff were noted to be performing ineffective CPR. Facility staff members reported Resident #271 had last been seen at approximately 8:30 P.M. but was not seen moving or talking. Upon seeing Resident #271 and the CPR that was being performed, the report noted apparent rigidity had set in. Resident #271 was checked for signs of life and was noted to be cold in his limbs and chest. Resident #271's mouth was noted to be stiff and unable to move. His right eye was partially open btu extremely cloudy and fixed. Resident #271's tongue was visible and cyanotic. Resident #271 had rigidity in his fingers, toes, neck, and back. A pillow was removed from behind Resident #271's head and the resident's head did not move from its position. A four-lead electrocardiogram (ECG) was taken and asystole (absence of heart rhythm which is incompatible with life). Resident #271's time of death was pronounced by EMS after collaboration with an outside emergency physician at 9:10 P.M. Review of Certified Nursing Assistant (CNA) #510's witness statement dated 09/30/25 stated about 8:10 P.M. she and CNA #509 proceeded to take Resident #271, who appeared to be sleeping, from the dining room to his room. Once they got Resident #271 into his room, they noticed his fingertips were blue, he was cold to touch and felt slightly hard. Following checking vitals, CNAs #509 and #510 ran to find RN #514. Upon RN #514 returning to the room with them, RN #514 started crying and panicking and stated, I don't do well with dead people. CNA #510 asked RN #514 if Resident #271 was a full code and RN #514 left the room to go check. About two minutes later, RN #514 returned and screamed put him in bed, we gotta do chest compressions. RN #514 asked CNAs #509 and #510 if they knew CPR and they said no. CNAs #509 and #510 put Resident #271 in bed and CNA #517 called EMS. RN #514 called RN #515 and screamed come over here and do chest compressions. CNA #510 stated Resident #271 did not have anything hard under his back. When RN #515 arrived, chest compressions were initiated until EMS arrived.Review of the witness statement from RN #515 dated 09/28/25 revealed while working on another unit, Unit Manager #516 received a phone call stating a code was called on the Fairmont unit. RN #515 and Unit Manager #516 rushed to Resident #271's room and found Resident #271 not breathing, without spontaneous movement of the chest, no audible sounds upon auscultation, no circulation, and eyes were fixed and dilated with no reaction to light. There was also no