

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 12/08/2025
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 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</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 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, drug package insert review, prescribing information review and review of the facility policy, the facility did not ensure residents were administered medications free of medication error rate of five percent or less. This affected two (Residents #171 and #173) out of six residents observed for medication administration. The facility census was 243. Findings include: Observation on 12/03/25 from 8:11 A.M. to 11:03 A.M. and 12/04/25 at 10:56 A.M. of medication administration completed by Licensed Practical Nurses (LPN)s #606, #611, #612, #614, and #615 revealed there were two medication errors out of 25 opportunities resulting in an eight percent medication error rate. 1. Review of the medical record for Resident #173 revealed an admission date of 07/15/21 with diagnoses including dysphagia, hypokalemia (low potassium), dementia, and atherosclerotic heart disease. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #173 had cognitive impairment as she was rarely or never understood. Review of the December 2025 physician orders revealed Resident #173 had an order dated 06/04/25 for potassium chloride extended release (ER) 20 milliequivalent (mEq) give one tablet by mouth in the morning for hypokalemia. The order revealed the medication was not to be crushed, and it was to be dissolved in 30 milliliters (ml) of water. Observation on 12/03/25 at 8:18 A.M. revealed LPN #611 placed Resident #173's morning medications in a cup including her potassium chloride ER 20 mEq and crushed the medications. LPN #611 then poured the crushed medications including the potassium chloride ER into a supplement drink. She proceeded to administer Resident #173's medication in the supplement drink. Interview on 12/03/25 at 8:32 A.M. with LPN #611 verified she crushed Resident #173's potassium chloride ER 20 mEq. She verified that the physician order revealed the following instructions: do not crush the potassium chloride and to dissolve in 30 ml of water to administer. Interview on 12/03/25 at 9:08 A.M. with Onsite Facility Pharmacist #613 verified potassium chloride ER was not to be crushed and revealed crushing the medication could result in releasing the medication faster than recommended as it was ER. 2. Review of the medical record for Resident #171 revealed an admission date of 05/08/23 with diagnoses including dementia and fractured right femur. Review of the quarterly MDS assessment dated [DATE] revealed Resident #171 had cognitive impairment as she was rarely or never understood. Review of December 2025 physician orders revealed Resident #171 had an order dated 09/05/25 to receive calcium carbonate- vitamin D 500 milligram (mg) - 5 microgram (mcg) tablet give two tablets by mouth two times a day. Observation on 12/03/25 at 8:34 A.M. revealed LPN #612 prepared Resident #171's morning medications including calcium carbonate- vitamin D 500 mg - 5 mcg one tablet, crushed the medications and administered Resident #171 the medications including one tablet of carbonate- vitamin D 500 mg - 5 mcg in applesauce. LPN #612 then proceeded to document the administration of the medications including the calcium carbonate- vitamin D. Interview on 12/03/25 at 8:41 A.M. with LPN #612 verified she had only administered one tablet of calcium carbonate- vitamin D 500 mg - 5 mcg to Resident #171. She verified Resident #171's physician order was to administer two tablets. Review of the facility policy dated 09/14/25 and unlabeled revealed the purpose of the policy was to provide guidance for medication administration in a safe manner as prescribed. The policy revealed prior to crushing medications staff would verify that the medication could be crushed. The policy revealed staff administering medications would check the label three times and verify the right resident, right medication, right dose, right time, right route, and right documentation. Review of Drugs.com dated 11/20/25 revealed the package insert and prescribing information for Potassium Chloride ER tablets were to be taken with meals and a glass of water or liquid. Potassium Chloride ER tablets were to be swallowed without crushing, chewing or sucking. This deficiency represents non-compliance investigated under Master Complaint Number 2679829 and Complaint Number 2679645.</p>		