

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 09/22/2025
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)		
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 at 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).		

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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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **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 the call light was within reach for Resident #173. This affected one resident (#173) of 15 residents on the 200-hall of the Beachwood unit and had the potential to affect all 259 residents residing in the facility. Findings include: Review of the medical record for Resident #173 revealed an admission date of 12/11/24. Diagnoses included dementia, arthritis of the knee, depression, diabetes and high cholesterol. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #173 was severely cognitively impaired. She was independent with eating, required partial to moderate assistance for oral hygiene, dressing, showering and personal hygiene and substantial to maximum assistance for toileting. Observation 09/09/25 at 7:45 A.M. revealed Resident #173 was lying in bed asleep. Her call light was hanging over the partition next to the bed, out of reach. Interview on 09/09/25 at 7:47 A.M. with Licensed Practical Nurse (LPN) #808 confirmed the call light in Resident #173's room was not within reach and should be accessible to her. She verified Resident #173 was capable of using the call light. Review of the facility policy titled Call Light Policy dated December 2023 revealed call lights would be within the reach of the resident in order to aide in requesting assistance and a timely response.		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, self-reported incident (SRI) review and facility policy review, the facility failed to ensure Resident #286 was free from physical abuse by Residents #259 and #201 and failed to ensure Resident #106 was free from physical abuse by Resident #275. This affected two (Residents #286 and #106) of eight residents reviewed for abuse and had the potential to affect all residents. The facility census was 259. Findings include: 1. Review of the medical record for Resident #106 revealed an admission date of 07/03/25. Diagnoses included encephalopathy (a disturbance in brain function that causes changes in mental state, behavior, and cognitive abilities), muscle weakness, kidney failure, communication deficit and dementia. Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #106 was severely cognitively impaired. He required partial to moderate assistance for eating, personal and oral hygiene and substantial to maximum assistance for toileting, showering and dressing. Review of the care plan dated 07/03/25 revealed Resident #106 required a locked unit due to wandering. Interventions included assessing reasons for restlessness, assisting with activities of daily living (ADL) and giving cues and reminders as necessary. 2. 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 quarterly MDS assessment dated [DATE] revealed Resident #259 was severely cognitively impaired. He required set-up help for eating, partial to moderate assistance for oral hygiene, and substantial to maximum assistance for toileting, personal hygiene and showering. 3. Review of the medical record for Resident #275 revealed an admission date of 11/12/24. Diagnoses included muscle weakness, dementia, communication deficit and bladder cancer. Review of the quarterly MDS assessment dated [DATE] revealed Resident #275 was severely cognitively impaired. He was independent in eating, oral hygiene, toileting, dressing and personal hygiene and required supervision for showering. Review of the care plan dated 06/20/25 revealed Resident #275 had the potential to be physically aggressive towards others. Interventions included physical and verbal cues to relieve anxiety, giving choices and intervening before agitation escalated. 4. Review of the medical record for Resident #286 revealed an admission date of 10/07/24. Diagnoses included Alzheimer's disease, psychosis, muscle weakness, kidney disease and pulmonary embolism. Review of the quarterly MDS assessment dated [DATE] revealed Resident #286 was severely cognitively impaired. She required supervision for eating and substantial or maximum assistance for oral hygiene, toileting, showering, dressing and personal hygiene. Review of the care plan dated 06/06/25 revealed Resident #286 required a locked unit due to wandering. Interventions included assessing reasons for restlessness, dementia education and providing for needs. 5. Review of the medical record for Resident #201 revealed an admission date of 07/19/23 with a diagnosis including late onset Alzheimer's disease. Review of the annual MDS 3.0 assessment dated [DATE] revealed Resident #201 had severe cognitive impairment. She had wandering behaviors four to six days of the seven-day assessment reference period. She required set-up and clean-up assistance with eating and was independent with ambulation. Review of the nursing progress note dated 03/05/25 and timed 2:46 P.M. revealed Resident #286 was walking in the hall with a bloody mouth. She did not state what happened. Review of investigation and SRI tracking number 257919 dated 03/05/25 revealed Resident #286 was observed walking in the hall with a bloody mouth. Resident #286 could not explain what happened. Resident #286 was separated from Resident #259, who reported he punched Resident #286 because she went into his room. Education was provided regarding the importance of not hitting people and calling for assistance. Both residents were assessed for injuries, and none were noted. (Resident #286 had a bloody mouth). The Administrator, DON and physician were notified. The facility SRI conclusion stated the investigation does not currently verify an abusive event occurred. The (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	investigation is inconclusive but resident-to-resident abuse is suspected. (Despite the diagnosis of dementia, this shows willful intent as Resident #259 explained why he punched resident #286 in the mouth). Review of SRI tracking number 261279 created on 06/05/25 at 4:44 P.M. revealed Resident #286 was pushed by Resident #201 in the dining room of the locked unit of Beachwood. Resident #286 hit her head on the floor and was sent to the emergency room (ER) for evaluation as a precaution. A hematoma was noted to her head. Staff members were present in the dining room but were unable to get to the residents fast enough. The narrative of the incident included Resident #201 carries around baby dolls to comfort her. Resident #286 came up to her in the dining room and started touching the baby dolls, and Resident #201 got upset and pushed Resident #286 backwards to get away from her and her baby doll. The facility unsubstantiated the Sri stating there was no willful intent by Resident #201. (Despite the diagnosis of late-stage Alzheimer's, this shows willful intent of Resident #201 pushing Resident #286 to get her away from her baby doll). Review of the nursing progress note dated 06/05/25 at 5:46 P.M. revealed Resident #286's son was notified of an altercation involving his mother and another resident (Resident #201). Resident #286 was being transferred to the hospital at the request of the physician. Review of the nursing progress note dated 06/06/25 at 2:00 A.M. revealed Resident #286 returned from the hospital with a large hematoma to the left side of the head. She was treated for a closed head injury. Review of investigation and SRI tracking number 263699 dated 08/06/25 revealed on 08/04/25 Residents #106 and #275 were involved in a physical altercation. Resident #275 said Resident #106 wandered into his room, so he hit him. Resident #275 was placed on one-to-one supervision, and Resident #106 was moved to a different unit. Head-to-toe assessments were completed, and Resident #106 was found to have a bump on his head and a bruise on his upper and lower lip. Resident #275 sustained a cut to his finger and complained of finger pain. An x-ray of Resident #275's right hand was obtained at the request of the physician and showed an acute fracture of the fifth digit. The facility conclusion stated the facility is unable to substantiate any wrongdoing of staff at this time. All staff were re-educated on resident-to-resident altercations as a preventative measure. Residents BIMS (Brief Interview for Mental Status) scores suggest they lack the mental capacity to intentionally induce harm on another. (Despite the diagnosis of dementia, this shows willful intent as Resident #275 explained why he hit Resident #106). Interview on 09/15/25 at 2:18 P.M. with the Director of Nursing (DON) verified the information in the above incidents. Review of the facility policy, Ohio Resident Abuse Policy, revised 07/11/24 revealed physical abuse was the willful act of hitting, slapping, punching or kicking of a resident. Willful meant the individual acted deliberately and not whether the individual intended to inflict injury.		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, self-reported incident (SRI) review and facility policy review, the facility failed to ensure allegations of resident-to-resident physical abuse were reported to the State Agency within two hours as required. This affected four (Residents #106, #259, #275 and #286) of eight reviewed for abuse and had the potential to affect all residents. The facility census was 259. Findings include: 1. Review of the medical record for Resident #106 revealed an admission date of 07/03/25. Diagnoses included encephalopathy (a disturbance in brain function that causes changes in mental state, behavior, and cognitive abilities), muscle weakness, kidney failure, communication deficit and dementia. Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #106 was severely cognitively impaired. He required partial to moderate assistance for eating, personal and oral hygiene and substantial to maximum assistance for toileting, showering and dressing. Review of the care plan dated 07/03/25 revealed Resident #106 required a locked unit due to wandering. Interventions included assessing reasons for restlessness, assisting with activities of daily living (ADL) and giving cues and reminders as necessary. 2. 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 quarterly MDS assessment dated [DATE] revealed Resident #259 was severely cognitively impaired. He required set-up help for eating, partial to moderate assistance for oral hygiene, and substantial to maximum assistance for toileting, personal hygiene and showering. 3. Review of the medical record for Resident #275 revealed an admission date of 11/12/24. Diagnoses included muscle weakness, dementia, communication deficit and bladder cancer. Review of the quarterly MDS assessment dated [DATE] revealed Resident #275 was severely cognitively impaired. He was independent in eating, oral hygiene, toileting, dressing and personal hygiene and required supervision for showering. Review of the care plan dated 06/20/25 revealed Resident #275 had the potential to be physically aggressive towards others. Interventions included physical and verbal cues to relieve anxiety, giving choices and intervening before agitation escalated. 4. Review of the medical record for Resident #286 revealed an admission date of 10/07/24. Diagnoses included Alzheimer's disease, psychosis, muscle weakness, kidney disease and pulmonary embolism. Review of the quarterly MDS assessment dated [DATE] revealed Resident #286 was severely cognitively impaired. She required supervision for eating and substantial or maximum assistance for oral hygiene, toileting, showering, dressing and personal hygiene. Review of the care plan dated 06/06/25 revealed Resident #286 required a locked unit due to wandering. Interventions included assessing reasons for restlessness, dementia education and providing for needs. Review of the nursing progress note dated 03/05/25 and timed 2:46 P.M. revealed Resident #286 was walking in the hall with a bloody mouth. She did not state what happened. Review of the abuse investigation and SRI tracking number 257919 dated 03/05/25 and timed 9:18 P.M. revealed on 03/05/25 at 11:00 A.M. Resident #286 was observed walking in the hall with a bloody mouth. Resident #286 could not explain what happened. Resident #286 was separated from Resident #259, who reported he punched Resident #286 because she went into his room. Education was provided regarding the importance of not hitting people and calling for assistance. Both residents were assessed for injuries, and none were noted. The Administrator, Director of Nursing (DON) and physician were notified. Review of the nursing progress note dated 03/06/25 at 10:52 P.M. revealed Resident #275 was found in the hallway with his knee on another residents' neck, stating he would hurt him. The residents were separated and physicians and families notified. (There was no SRI or investigation for this incident). Review of the abuse investigation and SRI tracking number 263699 dated 08/06/25 and timed 10:10 A.M. revealed on 08/04/25 Assistant Director of Nursing (ADON) #981 reported to the Administrator, Residents #106 and #275 were involved in a physical altercation. (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #275 said Resident #106 wandered into his room, so he hit him. Resident #275 was placed on one-to-one supervision, and Resident #106 was moved to a different unit. Head to toe assessments were completed and Resident #106 was found to have a bump on his head and a bruise on his upper and lower lip. Resident #275 sustained a cut to his finger and complained of finger pain. An x-ray of Resident #275's right hand was obtained at the request of the physician and showed an acute fracture of the fifth digit. Review of the nursing progress note dated 08/06/25 at 3:06 P.M. revealed Resident #275's daughter was notified of an incident that involved Resident #275. Interview on 09/15/25 at 2:18 P.M. with the DON revealed all SRI's involving potential resident abuse should be reported to the state within two hours. She confirmed SRI tracking number 257919 and SRI tracking number 263699 were not reported to the State Agency within the required time frame and the incident with Resident #275 on 03/06/25 was not reported to the State Agency at all. Review of the facility policy titled Ohio Resident Abuse Policy, dated 07/11/24, revealed all allegations of abuse, neglect, involuntary seclusion, exploitation of residents, misappropriation or injuries of unknown origin would be reported immediately to the Administrator. If the event involved an allegation of abuse or serious bodily injury, the incident would be reported to the State Department of Health no later than two hours after the allegation was made.		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, self-reported incident (SRI) review and facility policy review, the facility failed to ensure incidents of resident-to-resident incident physical abuse were thoroughly investigated. This affected four (Residents #106, #259, #275 and #286) of eight residents reviewed for abuse and had the potential to affect all residents. The facility census was 259. Findings include:1. Review of the medical record for Resident #106 revealed an admission date of 07/03/25. Diagnoses included encephalopathy (a disturbance in brain function that causes changes in mental state, behavior, and cognitive abilities), muscle weakness, kidney failure, communication deficit and dementia. Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #106 was severely cognitively impaired. He required partial to moderate assistance for eating, personal and oral hygiene and substantial to maximum assistance for toileting, showering and dressing. Review of the care plan dated 07/03/25 revealed Resident #106 required a locked unit due to wandering. Interventions included assessing reasons for restlessness, assisting with activities of daily living (ADL) and giving cues and reminders as necessary. 2. 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 quarterly MDS assessment dated [DATE] revealed Resident #259 was severely cognitively impaired. He required set-up help for eating, partial to moderate assistance for oral hygiene, and substantial to maximum assistance for toileting, personal hygiene and showering. 3. Review of the medical record for Resident #275 revealed an admission date of 11/12/24. Diagnoses included muscle weakness, dementia, communication deficit and bladder cancer. Review of the quarterly MDS assessment dated [DATE] revealed Resident #275 was severely cognitively impaired. He was independent in eating, oral hygiene, toileting, dressing and personal hygiene and required supervision for showering. Review of the care plan dated 06/20/25 revealed Resident #275 had the potential to be physically aggressive towards others. Interventions included physical and verbal cues to relieve anxiety, giving choices and intervening before agitation escalated. 4. Review of the medical record for Resident #286 revealed an admission date of 10/07/24. Diagnoses included Alzheimer's disease, psychosis, muscle weakness, kidney disease and pulmonary embolism. Review of the quarterly MDS assessment dated [DATE] revealed Resident #286 was severely cognitively impaired. She required supervision for eating and substantial or maximum assistance for oral hygiene, toileting, showering, dressing and personal hygiene. Review of the care plan dated 06/06/25 revealed Resident #286 required a locked unit due to wandering. Interventions included assessing reasons for restlessness, dementia education and providing for needs. Review of the nursing progress note dated 03/05/25 and timed 2:46 P.M. revealed Resident #286 was walking in the hall with a bloody mouth. She did not state what happened. Review of investigation and SRI tracking number 257919 dated 03/05/25 revealed Resident #286 was observed walking in the hall with a bloody mouth. Resident #286 could not explain what happened. Resident #286 was separated from Resident #259, who reported he punched Resident #286 because she went into his room. Education was provided regarding the importance of not hitting people and calling for assistance. Both residents were assessed for injuries, and none were noted. (Resident #286 had a bloody nose).The Administrator, DON and physician were notified. There was no evidence of vital signs were assessed for either resident, no assessment for range of motion and no evidence of the incident in either resident's medical record. The incident was not witnessed by staff. Review of the nursing progress note dated 03/06/25 at 10:52 P.M. revealed Resident #275 was found in the hallway with his knee on another residents' neck, stating he would hurt him. The residents were separated and physicians and families notified. (There was no SRI or investigation for this incident). Review of investigation and SRI tracking number 263699 created on 08/06/25 at 10:44 A.M. revealed on 08/04/25 Residents #106 and #275 were involved in a physical altercation. Resident #275 said (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #106 wandered into his room, so he hit him. Resident #275 was placed on one-to-one supervision, and Resident #106 was moved to a different unit. Head-to-toe assessments were completed, and Resident #106 was found to have a bump on his head and a bruise on his upper and lower lip. Resident #275 sustained a cut to his finger and complained of finger pain. An x-ray of Resident #275's right hand was obtained at the request of the physician and showed an acute fracture of the fifth digit. There was no evidence of vital signs for either resident, no assessment for range of motion and no evidence of the incident in either resident's medical record. The incident was not witnessed by staff, and the facility did not determine the root cause of the incident. Interview on 09/15/25 at 2:18 P.M. with the Director of Nursing (DON) revealed the facility considered all resident-to-resident incidents worthy of an investigation to rule out abuse. She confirmed that an SRI and investigation were not completed for the incident involving Resident #275 on 03/06/25. She also confirmed the investigations for SRI tracking numbers 257919 and 263699 were not comprehensive since they did not include a full resident assessment or root cause analysis. Interview on 09/16/25 at 12:50 P.M. with Licensed Practical Nurse (LPN) #704 revealed she did not recall the incident on 03/06/25 with Resident #275, but for an incident of this nature she would have notified the unit manager, the DON and the Administrator, as well obtained vital signs for both residents and assessed them for pain and injuries. Review of the facility policy titled Ohio Resident Abuse Policy dated 07/11/24 revealed the facility would investigate all allegations, incidents or suspicions of abuse, neglect, involuntary seclusion, exploitation of residents, misappropriation or injuries of unknown origin. If a resident is injured, staff would immediately report the incident to their supervisor, perform an assessment to include range of motion, vital signs a full body assessment for signs and symptoms of injury. The facility would document the results of the assessment in the nurses' notes, notification to the physician and responsible party and treatment provided.		

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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. **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 (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 attempting to swallow or take another bite. Interview on 09/10/25 at 12:30 P.M. with CNA #656, after Resident #195 completed eating her enchilada, revealed he was just assigned to pass the trays as he usually did not work on the [NAME] unit. He verified he gave Resident #195 her tray and was not aware if she needed fed, cued or reminded to slow down and chew her food thoroughly before attempting to swallow or take another bite during her meal. CNA #656 walked away and proceeded to continue to pass trays as Resident #195 continued to eat independently. Interview on 09/10/25 at 12:25 P.M. with ST #698 revealed Resident #195 was on and off the speech case load over the years due to dysphagia. She was currently on a maintenance program where ST checked in on her status every two weeks. She had a history of coughing on her food, eating at a fast pace, and taking a bite before chewing fully and swallowing the previous bite. She had a choking incident in the past, and staff were to remind her to double swallow, take small bites, alternate liquids and food, and slow down her rate of eating. Staff should be monitoring as she eats because Resident #195 had cognitive impairment and needed continuous reminders. She did not have any documented evidence that staff were trained on the dining interventions and stated the unit manager for the unit usually completed the education. Interview on 09/10/25 at 1:07 P.M. with RN Unit Manager #726 verified Resident #195 had a physician order that included she was to be fed by staff and required staff to sit with the resident, remind her to slow down and chew food thoroughly before attempting to swallow. She verified Resident #195 had a previous choking incident and needed monitored during meals as she ate with a fast pace as well as took bites of food without properly chewing and swallowing the previous bites. She revealed staff on the floor received a report sheet at the beginning of the shift that was detailed regarding the care needs of each resident and Resident #195's dining needs and interventions were on that report sheet. RN/ Unit Manager #726 went up to CNA #656 and requested the report sheet he had for Resident #195. CNA #656 revealed he had only grabbed Assignment A report sheet and not Assignment B which had Resident #195 on it. He verified again to RN/ Unit Manager #726 he was unaware Resident #195 had any specific dining interventions. RN/ Unit Manager #72 then located Assignment B report sheet in the nursing office and verified the report sheet identified that Resident #195 was not to have coffee, was on a soft honey thick liquid diet, no cold cereal, encourage oral fluids, and head of bed up at 45 degrees. She verified the report sheet was incorrect as Resident #195 was not on honey thick liquids instead she was on nectar and verified there was nothing on the report sheet regarding dining interventions including that she was to be fed by staff, staff were to sit with the resident, and remind her to slow down and chew food thoroughly before attempting to swallow as ordered. She verified she had no other education or training that staff would be aware of the dining interventions. Interview on 09/15/25 at 1:58 P.M. with the Director of Nursing (DON) verified Resident #195 had a physician order to be fed by staff, staff was to sit with Resident #195, remind her to slow down and chew her food thoroughly before attempting to swallow as she had a previous choking incident. She revealed there was no policy regarding feeding and/or dining interventions. 2. Review of the medical record for Resident #8 revealed an admission date of 03/12/25 with diagnoses including diabetes, hemiplegia following cerebral infarction affecting the right dominant side, major depression, hypertension, and depression. Review of the care plan dated 03/24/25 revealed Resident #8 had a self-care performance deficit related to hemiplegia following cerebral infarction. Interventions included providing a sponge bath when a full bath or shower cannot be tolerated, and he was totally dependent on one staff to provide a bath and/or shower as (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	necessary. There was no documented evidence in the care plan stating Resident #8 refused showers and/or personal hygiene. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #8 had impaired cognition with no behaviors identified. He had impairment on one side of his upper and lower extremities. He was dependent on staff for ADL including dressing, personal hygiene, transfers and showers. Review of the nursing notes from 07/01/25 to 09/11/25 revealed no documented evidence that Resident #8 refused a shower and/or personal hygiene. Review of the Skin Monitoring: Comprehensive CNA Shower Review sheets revealed Resident #8 received showers 07/14/25, 07/17/25, 07/28/25, 07/31/25, 08/04/25, 08/07/25, 08/08/25, 08/11/25, 08/14/25, 08/18/25, 09/01/25, 09/04/25, and 09/08/25, 09/11/25. There were no shower sheets from 07/17/25 to 07/28/25 indicating Resident #8 had gone ten days without a bath and/or shower. There also was no shower sheet from 08/18/25 to 09/01/25 indicating Resident #8 had gone 12 days without a bath and/or shower. The shower sheets dated 09/01/25, 09/04/25, 09/08/25 and 09/11/25 had the same signature located on the sheet but it was illegible to determine who the staff was that had given Resident #8 a shower and/or bath. Review of the monitoring task bar in the electronic medical record for bathing dated from 08/18/25 to 09/16/25 revealed no documented evidence Resident #8 had received a shower and/or bath. The task bar revealed he was scheduled to have a shower every Monday and Thursday on night shift. Interview and observation on 09/08/25 at 11:14 A.M. with Resident #8 revealed he was in bed, and his hair appeared greasy with white specks throughout. Resident #8 revealed he was supposed to get a shower twice a week on Monday and Thursday, and he had not had a shower in the last two weeks. He preferred a shower twice a week, but when he asked for a shower, they would never give him one. Observation on 09/10/25 at 8:47 A.M. revealed Resident #8 was lying in bed and his hair continued to appear unkept and greasy. Interview on 09/10/25 at 12:20 P.M. with Resident #8 revealed he still had not received a shower. He stated, staff had never offered a shower. Interview and observation on 09/11/25 at 7:48 A.M. revealed Resident #8 was lying in bed, and his hair continued to be unkept and greasy. Resident #8 stated he had not received a shower. Interview on 09/11/25 at 10:50 A.M. with CNA #674 verified Resident #8's hair was unkept and greasy. She revealed he was scheduled as an evening shift shower every Monday and Thursday. She did not feel he received the showers as scheduled as he often appeared with body odor and/or his hair was greasy. She revealed Resident #8 had also stated that he had not received a shower on his shower days, and he wanted a shower. She had often passed it on to the aides that came in that he needed and wanted a shower but often the next day she would come in and he still had not received the shower. Interview on 09/15/25 at 1:58 P.M. with the DON verified there were no shower sheets from 07/17/25 to 07/28/25 indicating Resident #8 had gone ten days without a bath and/or shower. There were also no shower sheet from 08/18/25 to 09/01/25 indicating Resident #8 had gone 12 days without a bath and/or shower. She was unable to identify who had given him a shower on 09/01/25, 09/04/25, 09/08/25 and 09/11/25 as the signature on the shower sheets was illegible and that they had contacted the staff on duty for that day and were unable to determine who provided the shower. She revealed they were still working on determining who had. Interview on 09/16/25 at 10:00 A.M. with the Administrator and DON revealed they were unable to determine which staff member signed off on the shower sheet for 09/01/25, 09/04/25, 09/08/25 and 09/11/25 as it is illegible and they contacted the staff on duty and were unable to determine who had provided Resident #8 the shower and/or bath for these days. Review of the facility policy labeled, Resident Bath/ Showering/ Scheduling, dated 09/09/22, revealed residents would be bathed or showered according to their preference in order to maintain hygiene and skin condition. Each resident would be scheduled to receive bathing a minimum of two times per week unless they prefer less frequently. When the bath or shower was completed, the staff would document on the shower sheet and/or the electronic record. If the bath or shower could not be given or the resident refused, the nursing assistant would report to the charge nurse. The charge nurse would speak with the resident to determine alternative arrangements and document the refusal in the medical record. This (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	deficiency represents non-compliance investigated under Complaint Numbers 2601023, 2562355, 1383330 (OH00166217), 1383336 (OH00165819), and 1383342 (OH00163342).		

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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 activities. 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).		

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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 or treatments were ordered or in place for her. (continued on next page)		

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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)		

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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.		

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NAME OF PROVIDER OR SUPPLIER King David Post Acute Nursing & Rehabilitation LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 27100 Cedar Rd Beachwood, OH 44122	
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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. **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 (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 09/11/25 at 7:20 A.M. revealed Resident #259 was lying asleep in his bed. A fall mat was noted to be folded up at the head of Resident #259's bed. There was no bolster mattress on Resident #259's bed. Interview at the time of the observation with Certified Nurse Aide (CNA) #854 confirmed Resident #259 never had a bolster mattress to his bed, and there was not one in place at that time. He also confirmed the fall mat should have been spread out on the side of Resident #259's bed, and it had been implemented as an intervention as a result of the fall on 07/24/25. (The fall mat was not noted on the fall investigation or on the care plan). Interview on 09/15/25 at 2:16 P.M. with the Director of Nursing (DON) confirmed the fall investigations for Resident #259 did not have all the necessary information to consider the investigations complete and thorough. Review of the facility policy titled Fall Prevention and Management Policy, dated 12/09/19, revealed residents would be assessed for falls on admission, quarterly and as needed. If risks were identified, preventative measures would be put in place and care planned, and all falls would be reviewed and investigated. Individualized interventions would be implemented and added to the care plan accordingly. This deficiency represents noncompliance investigated under Complaint Number 1383335 (OH00166244).		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, interview and review of facility policy, the facility failed to ensure oxygen tubing was dated when changed and proper signage on the entrance to a resident's rooms indicating oxygen was in use. This affected two residents (#45 and #93) out of two residents reviewed for respiratory needs. This had the potential to affect 16 additional residents (#2, #13, #27, #60, #79, #85, #101, #105, #122, #170, #177, #185, #193, #231, #242, and #272) identified by the facility as using oxygen. The facility census was 259. Findings include: 1. Review of the medical record for Resident #93 revealed an admission date of 11/27/23 with diagnoses including acute and chronic respiratory failure with hypoxia (low level of oxygen in body tissues), hypertension, and congestive heart failure (CHF). There was nothing in the medical record to indicate when Resident #93's oxygen tubing was changed. Review of the physician order dated 07/25/25 revealed Resident #93 had an order for oxygen at two liters per nasal cannula (a flexible tube with prongs that fit into the nostrils to deliver oxygen) as needed for hypoxia and oxygen saturation level below 92 percent. There were no orders regarding the frequency of when the oxygen tubing was to be changed. Review of the care plan dated 07/28/25 revealed Resident #93 tested positive for COVID-19. Interventions included administering medications as ordered, monitoring for presence of symptoms including shortness of breath, and reporting worsening signs and symptoms of infection or lack of improvement from treatment. There was nothing in the care plan regarding oxygen use. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #93 had intact cognition, and he was not identified as using oxygen. Observation on 09/08/25 at 11:40 A.M. revealed Resident #93 had a green e-cylinder (a cylinder with oxygen) in a holder sitting by his wall in his room with a nasal cannula hanging on top of the cylinder. The nasal cannula tubing was undated. There was no signage on the outside of the room indicating Resident #93 was on oxygen. Interview on 09/08/25 at 11:40 A.M. with Resident #93 revealed he wears oxygen when needed, but that it had been a while. He was unsure when the last time the nasal cannula tubing was changed. Interview on 09/08/25 at 11:44 A.M. with Registered Nurse (RN) #913 and Licensed Practical Nurse (LPN) #859 verified there was no date on Resident #93's nasal cannula tubing and no signage on the outside of his room indicating Resident #93 had oxygen. 2. Review of the medical record for Resident #45 revealed an admission date of 10/24/23 with diagnoses including muscle weakness, hypertension, and chronic kidney disease. There was nothing in the medical record to indicate when Resident #93's oxygen tubing was changed. Review of the care plan dated 07/28/25 revealed Resident #45 tested positive for COVID-19. Interventions included administering medications as ordered, monitoring for presence of symptoms including shortness of breath, and reporting worsening signs and symptoms of infection or lack of improvement from treatment. There was nothing in the care plan regarding oxygen use. Review of the quarterly MDS 30 assessment dated [DATE] revealed Resident #45 had intact cognition and used oxygen. Review of the September 2025 physician's orders revealed Resident #45 had an order dated 07/28/25 for continuous oxygen at two liters per nasal canula, check placement, and record oxygen saturation every shift. There was no order to change her oxygen tubing. Observation on 09/08/25 at 11:35 A.M. revealed Resident #45 was lying in bed and had a green oxygen cylinder in her bathroom as well as an oxygen concentrator (a device that extracts oxygen from the surrounding air to deliver an oxygen-enriched gas stream to a patient) next to her bed. The oxygen concentrator had a nasal cannula connected that was not dated as to when it was last changed. There was no signage on the outside of the room indicating Resident #45 was on oxygen. Interview on 09/08/25 at 11:44 A.M. with RN #913 and LPN #859 verified there was no date on Resident #45's nasal cannula tubing and no signage on the outside of her room indicating Resident #45 had oxygen. Interview on 09/15/25 at 1:58 P.M. with the Director of Nursing (DON) verified any rooms that contain oxygen should have signage upon entrance indicating oxygen was in use for safety. She also verified all oxygen tubing should be (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	changed once a week, and the nurse should label the tubing when they changed it and/or there should be an order on the treatment administration record (TAR) as to frequency, and the nurse should document the oxygen tubing changes. She verified Residents #45 and #93 did not have orders on their TAR indicating when their oxygen tubing was changed and/or anything in their medical record regarding when their tubing was changed last. Review of the undated facility policy labeled, Oxygen Storage and Handling Practices revealed the purpose of the policy was to ensure safe storage, handling and accessibility of oxygen cylinders and concentrators. There was nothing in the policy regarding ensuring proper signage was present indicating oxygen was in use and/ or there was nothing in the policy regarding labeling of oxygen tubing when it was changed.		

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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. **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 (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 dialysis residents were assigned to a specific driver and kept on their schedule to help with continuity. On 05/13/25, the transportation policy was reviewed by the interdisciplinary team including the unit managers and Regional Nurse Director #672. No changes to the policy were needed. Beginning 05/13/25, audits were conducted by Regional Nurse Director #672 or designee weekly for four weeks then monthly for two months. Results of the audits and any negative findings were forwarded to the QAPI (Quality Assurance and Performance Improvement) committee. On 05/22/25, Activities Coordinator #845 reminded all residents in the monthly Resident Council meeting of the facility providing transportation to outside medical appointments when necessary either by facility or insurance related transport. This deficiency represents non-compliance investigated under Complaint Number 1383325 (OH00163377).		

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews and facility policy review, the facility failed to adequately provide trauma-informed care to Residents #8 and #74. This affected two residents (#8 and #74) out of two residents reviewed for trauma-informed care. This had the potential to affect four residents (#8, #74, #81, and #157) identified by the facility with a diagnosis of post-traumatic stress disorder (PTSD). The facility census was 259. Findings include:1. Review of the medical record for Resident #8 revealed an admission date of 03/12/25 with diagnoses including PTSD (on admission), diabetes, hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side, and major depression. Review of the Social Service Initial Evaluation dated 03/14/25 and completed Social Service Designee (SSD) #844 revealed on Resident #8's evaluation under trauma informed care, it asked if the resident reported or if the medical record reflected any history of trauma, and it stated it was unable to be determined. The evaluation also asked if Resident #8 experienced trauma and/or had any triggers, but the areas were blank. Review of the comprehensive care plan dated 03/18/25 revealed Resident #8 did not have a care plan that included the diagnosis of PTSD, triggers, and/or interventions regarding trauma-informed care. Review of the Psychiatric Initial assessment dated [DATE] and completed by Psychiatric Nurse Practitioner (NP) #505 revealed staff referred Resident #8 to her due signs of depression, withdrawal, agitation and trauma/stressor related disorder. The note revealed Resident #8 would be non-verbal with staff and family without reason, history of behaviors, and he had trauma from war. The note revealed Resident #8 had current symptoms of sad moods, loss of interest, fatigue, decreased concentration and appetite change. The assessment revealed he scored four out of five on the Primary Care PTSD Screen for DSM-5 (PC-PTSD) assessment as he chose not to answer the last question. The assessment revealed he had positive trauma history and reported current emotional symptoms indicating probable PTSD. Review of Social Service Initial Evaluation dated 06/12/25 completed by SSD #844 revealed Resident #8 did not have a history of trauma/PTSD, did not have disturbing memories, thoughts or images of stressful experiences from the past, and under the area of triggers, it was blank. Review of quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #8 had impaired cognition. He was identified to have PTSD. Review of the Psychiatric Subsequent assessment dated [DATE] and completed by Psychiatric NP #505 revealed Resident #8 was evaluated for depression, withdrawal, agitation and trauma/stressor related disorder. The note revealed Resident #8 would go non-verbal with staff and family without reason, history of behaviors, and he had trauma from war. The report revealed that staff reported history of sad moods, loss of interest, fatigue, agitation, and decreased concentration. Interview on 09/10/25 at 12:20 P.M. with Resident #8 revealed he was abused at a previous facility as he stated, a big heavy-set guy punched me hard multiple times in the chest. I got beat up so I just always felt it would happen again. He also revealed he served in the military for many years including in a war. He did not want to share any further details. (continued on next page)		

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 09/11/25 at 9:28 A.M. with Director of Social Service #812 revealed she had worked at the facility since 07/28/25, and Resident #8 was admitted prior to her working at the facility. She verified Resident #8 had a diagnosis of PTSD on admission. She verified per the psychiatric notes; Psychiatric NP #505 had identified Resident #8 as having PTSD that was triggered by war as he had served in the military. She verified the social service assessments dated 03/14/25 and 06/12/25 revealed under the trauma informed care, it was answered unable to be determined if he had previous trauma, and there was no further assessment assessing his PTSD and/or his triggers. She revealed she was unsure why the assessment did not identify his PTSD and/or triggers. She revealed if a resident had PTSD, social service was to assess and develop a care plan identifying the PTSD, triggers and possible interventions. She verified Resident #8 did not have a care plan regarding PTSD, triggers and/or interventions. Review of the facility policy labeled, Post-Traumatic Stress Disorder (PTSD), dated February 2018, revealed the purpose of the policy was to provide trauma- informed care and services to residents with PTSD. The policy revealed residents would be screened for PTSD history and symptoms during admission and routine assessments. Individualized care plans would include known triggers and calming interventions. The policy revealed all PTSD related care, interventions, and episodes would be documented in the medical record. 2. Review of the medical record revealed Resident #74, was admitted to the facility on [DATE] with diagnoses including generalized osteoarthritis, generalized weakness, history of substance abuse, schizophrenia and post-traumatic stress disorder (PTSD). Review of the MDS 3.0 assessment dated [DATE] revealed Resident #74 required substantial to maximal assistance with showering and personal hygiene and was dependent for toileting. A Brief Interview for Mental Status (BIMS) score of nine out of 15, revealed the resident was cognitively impaired. Review of the Social Service Initial Evaluation dated 07/23/25 and completed SSD #844 revealed on Resident #74's evaluation under trauma informed care it was asked if the resident reported or if the medical record reflected any history of trauma, and it stated no. The evaluation also asked if Resident #74 experienced trauma and/or had any triggers, but the areas were blank. The assessment also asked if Resident #74 had been followed with psychiatry at the facility and had a psychiatric follow up been scheduled or completed; the answer was no to both questions. When reviewed on 09/11/25, the care plan completed on 08/06/25 revealed there was no care planning for the Resident #74's PTSD diagnosis. The care plan was revised on 09/15/25 to add a care plan for PTSD and interventions, after the facility had been advised of the lack of care planning for residents with PTSD. Resident #74 was admitted to the facility with the PTSD diagnosis on 04/16/25, and the care plan for PTSD was absent until 09/15/25. Interview on 09/16/25 1:07 P.M. MDS Coordinator #921 confirmed the new PTSD care plan was added on 09/15/25. Review of the facility policy labeled, Post-Traumatic Stress Disorder (PTSD), dated February 2018, revealed the purpose of the policy was to provide trauma- informed care and services to residents with PTSD. The policy revealed residents would be screened for PTSD history and symptoms during admission and routine assessments. Individualized care plans would include known triggers and calming interventions. The policy revealed all PTSD related care, interventions, and episodes would be documented in the medical record.		

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 09/22/2025
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)		
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, observation and review of facility policy, the facility failed to ensure medical records were accurate and/or legible. This affected two residents (#8 and #91) out of 44 resident records reviewed for accuracy and/or identifiable information. The facility census was 259. Findings include: 1. Review of the medical record for Resident #91 revealed an admission date of 05/15/25 with diagnoses including dysphagia, moderate protein-calorie malnutrition, adult failure to thrive, and dementia. Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #91 had impaired cognition and was dependent on staff for eating. She held food in her mouth and cheeks and received nutrition through parenteral feedings (a medical treatment that provides essential nutrients directly into the bloodstream through an intravenous (IV) line). Review of the After Visit Summary revealed Resident #91 was hospitalized from [DATE] to 09/02/25 as she was admitted to the hospital due to her [NAME] catheter (central venous catheter used to deliver medications, fluids, and nutritional supplements) malfunctioned and she needed the catheter replaced. She was discharged back to the facility on total parenteral nutrition (TPN). Review of September 2025 physician orders revealed Resident #91 had an order for TPN due to malnutrition. The TPN was to start at 8:00 P.M. at 68 milliliters (ml) for one hour, then increase the rate to 136 ml per hour for 10 hours and then decrease the rate to 68 ml per hour until 8:00 A.M. Review of September 2025 Medication Administration Record (MAR) revealed Resident #91's MAR for her TPN at 8:00 P.M. was not signed as administered on 09/06/25, 09/09/25 and 09/10/25. Interview on 09/09/25 at 8:55 A.M. with Resident #91's son revealed he felt his mother missed doses of TPN. Interview on 09/15/25 at 8:52 A.M. with Dietitian #951 verified the MAR for Resident #91's TPN on 09/06/25, 09/09/25 and 09/10/25 was blank. She verified she had no documented evidence that Resident #91's TPN was administered on 09/06/25, 09/09/25 and 09/10/25. Review of an email dated 09/15/25 at 12:12 P.M. from Registered Nurse (RN) Supervisor #763 to Regional Nurse #672 revealed she hung Resident #91's TPN on 09/10/25 and made sure it was running but did not sign it off. Review of an email dated 09/15/25 at 3:30 P.M. from RN Supervisor #614 to Regional Nurse #672 revealed during her shifts on 09/06/25 and 09/09/25 she hung and monitored Resident #91's TPN. Interview on 09/15/25 at 3:34 P.M. with the Director of Nursing (DON) verified the MAR for Resident #91's TPN on 09/06/25, 09/09/25 and 09/10/25 was blank. She revealed the TPN was administered according to the emails by the nurse that was responsible for hanging the TPN but verified they had not documented on the MAR that they were administered. Interview on 09/16/25 at 9:16 A.M. with RN Supervisor #763 verified on 09/10/25 she hung Resident #91's TPN as ordered but forgot to document on the MAR that she administered it. Review of the facility policy labeled, Total Parental Nutrition (TPN) Administration Policy, dated February 2014, revealed all orders, lab monitoring and TPN administration must be documented in the electric medical record. 2. Review of the medical record for Resident #8 revealed an admission date of 03/12/25 with diagnoses including diabetes, hemiplegia following cerebral infarction affecting right dominant side, major depression, hypertension, and depression. Review of the care plan dated 03/24/25 revealed Resident #8 had a self-care performance deficit related to hemiplegia following cerebral infarction. Interventions included providing a sponge bath when a full bath or shower could not be tolerated, and he was totally dependent on one staff to provide a bath and/or shower as necessary. There was nothing in the care plan regarding Resident #8 refusing showers and/or personal hygiene. Review of the quarterly MDS 3.0 assessment dated [DATE] revealed Resident #8 had impaired cognition with no behaviors identified. He had impairment on one side of his upper and lower extremities. He was dependent on staff for activities of daily living (ADL) including dressing, personal hygiene, transfers and showers. Review of the nursing notes from 07/01/25 to 09/11/25 revealed no documented evidence that (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER King David Post Acute Nursing & Rehabilitation LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 27100 Cedar Rd Beachwood, OH 44122	
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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #8 had refused a shower and/or personal hygiene. Review of the electronic monitoring task bar for bathing from 08/18/25 to 09/16/25 revealed no documentation Resident #8 had received a shower and/or bath. The task bar revealed he was scheduled to have a shower every Monday and Thursday on night shift. Review of the Skin Monitoring: Comprehensive CAN (certified nursing assistant) Shower Review sheets revealed Resident #8 received a shower or bath on 09/01/25, 09/04/25, 09/08/25, and 09/11/25. The shower sheets dated 09/01/25, 09/04/25, 09/08/25 and 09/11/25 had the same signature located on the sheet, but the signature was illegible to determine who the staff was that had given Resident #8 a shower and/or bath. Interview and observation on 09/08/25 at 11:14 A.M. with Resident #8 revealed he was in bed and his hair appeared greasy with white specks throughout. Resident #8 revealed he was supposed to get a shower twice a week on Monday and Thursday, and he had not had a shower in the last two weeks. He preferred a shower twice a week but when he asked for a shower, they would never give him one. Observation on 09/10/25 at 8:47 A.M. revealed Resident #8 was lying in bed, and his hair continued to appear unkempt and greasy. Interview on 09/10/25 at 12:20 P.M. with Resident #8 revealed he still had not received a shower, and staff had never offered a shower. Interview and observation on 09/11/25 at 7:48 A.M. revealed Resident #8 was lying in bed and his hair continued to be unkempt and greasy. Resident #8 revealed he had not received a shower. Interview on 09/11/25 at 10:50 A.M. with CNA #674 verified Resident #8's hair was unkempt and greasy. She revealed he was scheduled as an evening shift shower every Monday and Thursday. She did not feel he received the showers as scheduled as he often appeared with body odor and/or greasy hair. Resident #8 had also stated that he had not received a shower on his shower days, and he wanted a shower. She had often passed it on to the aides that came in that he needed and wanted a shower but often the next day she would come in and he still had not received the shower. Interview on 09/15/25 at 1:58 P.M. with the DON revealed she was unable to identify who had given Resident #8 a shower on 09/01/25, 09/04/25, 09/08/25 and 09/11/25 as the signature on the shower sheets was illegible and they had contacted the staff on duty for that day and were unable to determine who provided the shower. They were still working on to determine who had. Attempted to contact the following staff that had worked on the identified days (09/01/25, 09/04/25, 09/08/25 and 09/11/25): CNA 779, CNA #977, and CNA #943 on 09/16/25 from 11:00 A.M. to 1:05 P.M. but there was no answer, and no return call was received. Interview with staff that had worked the identified days (09/01/25, 09/04/25, 09/08/25 and 09/11/25) on 09/16/25 from 11:03 A.M. to 1:02 P.M. with CNA #637, CNA #790, and CNA #827 revealed they did not give Resident #8 a shower and/ or bath and had not witnessed him receive one. Interview on 09/16/25 at 10:00 A.M. with the Administrator and DON revealed they were unable to determine the staff that had signed off on the shower sheet for 09/01/25, 09/04/25, 09/08/25 and 09/11/25 as the signature was illegible. They had contacted the staff on duty and were unable to determine who provided Resident #8 the shower and/or bath for these days. The DON revealed she did not have a policy regarding ensuring medical records had identifiable, legible, and accurate information. Review of facility policy labeled, Resident Bath/ Showering/ Scheduling, dated 09/09/22, revealed residents would be bathed or showered according to their preference in order to maintain hygiene and skin condition. The policy revealed when the bath or shower was completed, the staff would document on the shower sheet and/or electronic record. If the bath or shower could not be given or the resident refused, the nursing assistant would report to the charge nurse.		