

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365445	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/22/2026
NAME OF PROVIDER OR SUPPLIER Beechwood Home for Incurables		STREET ADDRESS, CITY, STATE, ZIP CODE 2140 Pogue Avenue Cincinnati, OH 45208	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>Based on observations, policy review, staff interviews, and record review, the facility failed to ensure call lights were within reach of the residents. This affected two (Resident #362 and #543) of the 70 residents who are able to utilize the call light system. The facility census was 73. Findings include: 1. Medical record review for Resident #362 revealed an admission date of 09/15/06. Diagnoses included multiple sclerosis (MS), lack of coordination and epilepsy. Care plan intervention revealed Resident #362 was able to use call light system when placed in right hand. Velcro strap needs to be attached to call light is wrapped around right hand and resident brings call light up to his chin to activate. Observation and interview on 01/22/26 at 11:00 A.M. revealed Resident #362 sitting upright in his wheelchair in his room and his call light was lying on the floor next to him, and was out of his reach. Certified Nursing Aide (CNA) #219 verified the call light was out of reach for Resident #362. CNA #219 retrieved the call light and placed it under his right arm and in his right hand. There was no Velcro strap attached to the call light. Interview with Registered Nurse (RN) #241, the third floor unit manager, on 01/22/26 at 11:05 A.M. revealed Resident #362 has been equipped with a Velcro strap that attaches to the call light cord and goes over his right hand, so he can press the call button to his chin. Observation on 01/22/26 at 11:07 A.M. revealed Resident #362 made multiple attempts to press his call light utilizing his chin but the call light fell from his grasp onto the floor. There was no Velcro strap visible. Interview with RN #241 and Psychiatric Nurse Practitioner (PNP) #110 on 01/22/26 at 11:16 A.M. revealed PNP #110 verified the call light was out of reach when he arrived in Resident #362's room. RN #241 and PNP #110 verified there was no Velcro strap attached to the call light; they scanned the room for the strap and were unable to locate. RN #241 made a telephone call while in Resident #362's room requesting the therapy department to come with a Velcro strap for the call light. 2. Medical record review for Resident #543 revealed an admission date of 10/24/24. Diagnoses included amyotrophic lateral sclerosis (ALS), respiratory failure with hypercapnia, and Parkinson's disease. Observation and interview on 01/22/26 at 9:25 A.M. revealed Resident #543 was in his bed with his call light sitting on the bedside nightstand, out of his reach. Licensed Practical Nurse (LPN) #200 verified the call light was out of reach for Resident #543. LPN #200 picked up the call light and placed it across the Resident #543's stomach. Interview with the Director of Nursing (DON) and Administrator on 01/22/26 at 1:15 P.M. verified when residents were brought back to their rooms, following resident care and assistance with activities of daily living (ADLs), the expectation was for the residents to be provided with a call light using the tools they require according to the individual care plans. Review of the facility's Nurse Call System Policy, last reviewed on 08/14/20, revealed the facility will provide a means for residents to make staff aware of care needs at all times, including utilizing different devices wherein the need for modification has been determined necessary. This was an incidental finding discovered during the complaint survey.</p>		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 365445	Facility ID: 365445 If continuation sheet Page 1 of 1