STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365445	A. Building B. Wing	05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beechwood Home for Incurables	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)
F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility failed to ensure the level one Preadmission Screening and Resident Review (PASARR) accurately reflected a resident's existing mental illness at the time of admission. This affected one (Resident #69) of two residents reviewed for PASARR . Findings include: Review of Resident #69's medical record revealed Resident #69 admitted to the facility on [DATE]. Diagnoses included dementia, post-traumatic stress disorder (PTSD), and epilepsy. Review of the PASARR Identification Screen dated 02/09/23 revealed Resident #69 did not have any of the diagnoses or disorders listed on the form. Mood disorder, panic or other severe anxiety disorder, and another mental disorder that may lead to a chronic disability were included in the list of diagnoses; however, none of the diagnoses were selected as applicable to Resident #69. Review of Resident #69's five-day Minimum Data Set (MDS) assessment dated [DATE] revealed PTSD was selected as an active diagnosis under psychiatric/mood disorder. During an interview on 05/22/25 at 10:30 A.M., the Director of Social Services (DSS) #500 stated the facility did not have a policy for PASARRs. During an interview on 05/22/25 at 1:00 P.M., the Director of Nursing (DON) verified Resident #69's PASARR level one dated 02/09/23 should have been marked with a mood disorder and stated her expectation going forward was that the PASARR would be reviewed upon admission, and corrections would be made based on the resident's diagnoses and medical records. During an interview on 05/22/25 at 1:04 P.M., the Administrator stated going forward they would review the PASARR upon admission, make corrections based on the resident's diagnoses and medication records, and ensure the PASARR was correct.

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, record review, and facility policy review, the facility failed to ensure a resident was free from significant medication errors, when the facility failed to follow a physician's order to hold a blood pressure medication when the systolic blood pressure (SBP), the top number in a blood pressure (BP)) reading was above 120. This affected one (Resident #7) of six residents reviewed for unnecessary medications. The facility census was 73. Findings include: Review of Resident #7's medical record revealed the resident was admitted to the facility on [DATE]. Diagnoses included cerebral palsy, hyperlipidemia, and acute kidney failure. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #7 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. Review of the care plan revealed a focus area revised on 03/23/20, which indicated Resident #7 had an alteration in cardiac status. Interventions included directing staff to provide medications and labs as ordered and to obtain vital signs as ordered. Review of Resident #7's Order Summary Report, with active orders as of 05/22/25 revealed an order dated 02/18/25, for Midodrine HCL (hydrochloride) (treats low blood pressure) oral tablet 10 milligrams (mg), one tablet by mouth three times a day for hypotension (low blood pressure), with instructions to hold for systolic blood pressure greater than 120. Review of the Medication Administration Record (MAR) from 05/01/25 to 05/21/25, revealed staff administered the Midodrine HCL oral tablet 10 mg to Resident #7 when the resident's SBP was greater than 120 on 05/03/25 at 2:00 P.M. (SBP was 127), 05/04/25 at 2:00 P.M. (SBP was 146), 05/05/25 at 2:00 P.M. (SBP was 125), 05/07/25 at 2:00 P.M. (SBP was 133), 05/08/25 at 2:00 P.M. (SBP was 136), 05/12/25 at 2:00 P.M. (SBP was 125), 05/13/25 at 2:00 P.M. (SBP was 129), 05/14/25 at 8:30 A.M. (SBP was 141) and 2:00 P.M. (SBP was 127), 05/18/25 at 2:00 P.M. (SBP was 150), 05/19/25 at 2:00 P.M. (SBP was 142), and 05/21/25 at 2:00 P.M. (SBP was 131). During an interview on 05/22/25 at 9:40 A.M., Licensed Practical Nurse (LPN) #1 stated blood pressure parameters were located in the physician's order on the MAR. She stated if Resident #7's SBP was higher than 120 and the medication was not held, it would be considered a medication error. LPN #1 stated when the nurses documented a held medication, it would auto populate in the progress notes. She said if no number was entered on the MAR for the reason a medication was held, and no progress note indicated the medication was held, then the checkmark on the MAR meant the medication was given. LPN #1 confirmed multiple doses of medication that were outside of the parameters of the order, were documented as given with her initials and a checkmark. LPN #1 stated if she did not document the medication was held, then it was probably given, but she could not say for sure. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/22/25 at 10:37 AM, Registered Nurse (RN) #3 stated if a medication was ordered to be held for a SBP over 120 and was not, it would be a medication error. RN #3 stated if there was not a numeric reason a medication was held or a progress note for the reason a medication was held, then a checkmark in the box on the MAR meant a medication was given. RN #3 reviewed Resident #7's Midodrine order and agreed there were multiple times the medication was recorded as given when it should not have been, based on the blood pressure recorded. She stated for the days where the medication was coded as held and there was no progress note, that it was held, but the checkmark meant they gave the medication when they should not have and that it was a medication error. During an interview on 05/22/25 at 10:49 A.M., RN #4 stated parameters for a medication should be in the order and should show up on the MAR. She stated if a medication was given outside of those parameters, it would be a medication error. During an interview on 05/22/25 at 12:11 P.M., the Director of Nursing (DON) confirmed there were multiple times where there was no documentation in the progress notes or on the MAR that the medications were held when the SBP was over 120 for Resident #7. She stated her expectation was for the nurses to take vital signs prior to administering the medications, and if the value was outside of the parameters, the nurse should hold the medication, document it was held, and the reason it was held. The DON stated that if there was a checkmark in the box on the MAR, no numeric value to indicate it was held, and no progress note for the reason it was held, it would be considered a medication error. During an interview on 05/22/25 at 12:41 P.M., the Administrator stated she deferred to nursing for the clinical portion, but she would expect the nurses to follow the physician's order and hold the medications when they needed to be held. Review of the facility policy titled Medication Administration dated 11/01/24 revealed nurses will administer medications safely and effectively following the five rights of medication administration. Nurses will follow physician/physician extender orders regarding medication administration. Vital signs and other measurements will be checked prior to administering medications with parameters as indicated/ordered. The facility policy titled Medication Regimen - Unnecessary Medications dated 11/01/24 revealed each resident's drug regimen will be free of unnecessary drugs.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, staff interview, and facility policy review, the facility failed to maintain appropriate infection control practices during Resident #42's wound care. This affected one (#42) of two residents observed for wound care. Findings include: Review of Resident #42's medical record revealed the resident admitted to the facility on [DATE]. Diagnoses included ataxia, pneumonia, and acute embolism and thrombosis of deep veins of lower extremity. Review of the significant change Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #42 had intact cognition. Resident #42 had one unstageable pressure ulcer (slough and/or eschar: known but not stageable due to coverage of wound bed by slough and/or eschar) and received pressure ulcer care. Review of the care plan dated 03/04/25 revealed Resident #42 had a pressure area to their sacrum. Interventions included for staff to provide treatment per physician orders. Review of Resident #42's active physician orders dated 5/21/25 revealed there were treatment orders to clean the sacrum area with soap and water, tap dry, and apply a treatment to the wound and apply an abdominal (ABD) pad. During an observation of wound care for Resident #42 on 05/21/25 at 1:37 P.M., Licensed Practical Nurse (LPN) #1 donned a gown and gloves. LPN #1 did not perform hand hygiene prior to placing the gloves on. With gloved hands, she reached for Resident #42's electronic bed control and raised the bed prior to starting the wound treatment. With the same gloves on, LPN #1 pulled the bedside table to within reach, turned and assisted Resident #42 to roll to their left side, and loosened the incontinence brief and pulled it to the side to gain access to the wound. Without changing gloves, LPN #1 cleaned the wound with four-by-four gauze pads and soap and water then rinsed the wound with four-by-four gauze pads and normal saline. Without changing gloves, LPN #1 grabbed two dry four-by-four gauze pads and patted the wound bed dry. Without changing gloves or performing hand hygiene, LPN #1 grabbed a tube of lidocaine gel, squirted a dime-size amount on her gloved right index finger and applied the gel over the wound bed. Again without changing gloves or performing hand hygiene, LPN #1 grabbed a 30 cubic centimeter medication cup with skin barrier cream in it and squirted a small amount of Silvadene cream into the cup, then mixed the two creams together with a tongue blade. LPN #1 then used the tongue blade to apply the mixture over the wound bed. Without changing gloves or performing hand hygiene, LPN #1 grabbed an ABD pad, placed it over the wound, and then closed Resident #42's brief. LPN #1 then threw away the used supplies and doffed her gloves and gown. LPN #1 did not perform hand hygiene after removing her gloves and gown. At no time prior to donning gloves and gown for Resident #42's wound care, during the wound care, or immediately after she took off her gloves following Resident #42's wound care did LPN #1 perform hand hygiene. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/21/25 at 1:51 P.M., LPN #1 verified she did not perform prior to donning her gown and gloves, did not change gloves and perform hand hygiene in between the dirty and clean part of wound care, and did not perform hand hygiene when she completed wound care for Resident #42 and removed her gown and gloves. LPN #1 stated she should have completed the hand hygiene prior to placing the gown and gloves on, changed her gloves in between dirty and clean part of wound care, and after wound care and removing gown and gloves. During an interview on 05/22/25 at 9:42 A.M., LPN #2 stated a nurse should wash their hands before and after a wound treatment and in between wounds, should a resident have more than one wound. She stated if a nurse donned a gown and gloves at the beginning of a wound treatment and did not change gloves or wash their hands throughout the entire process, this would be a breach of infection control. During an interview on 05/22/25 at 10:00 A.M., Registered Nurse (RN) #3, who was a Nursing Supervisor, stated a nurse should put on gloves going into the room, change gloves in between dirty and clean processes of wound care, and sanitize their hands in between glove changes. She stated if a nurse put on gloves at the beginning of a wound treatment and did not change them or wash their hands throughout the process, it would be considered a breach in infection control practice. RN #3 could not remember when her last in-service on infection control or wound care was. During an interview on 05/22/25 at 12:11 P.M., the Director of Nursing (DON) stated her expectation was for the nurse to wash their hands prior to putting on gloves and to remove their gloves after removing the soiled dressing and sanitize their hands. The DON stated the nurse should then re-glove, clean the wound, and remove their gloves again and sanitize their hands. Per the DON, the nurse would then re-glove and perform the treatment for the wound and then remove their gloves when finished with the treatment and wash their hands. The DON stated the nurses should be changing gloves between dirty and clean processes of the treatment. During an interview on 05/22/25 at 12:41 P.M., the Administrator stated her expectation was for the nurses to change gloves when they were supposed to for infection control practices during wound care. Review of the facility policy titled Dressing Change revised 11/01/22 revealed staff were to follow the procedure: 1. Perform hand hygiene 2. Put on clean gloves. 3. Remove the old dressing and dispose of it. 4. Clean the wound per physician order 5. Perform hand hygiene 6. Put on clean gloves 7. Apply treatment per physician order, if applicable. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8. Apply the new dressing and secure it in place. 9. Remove gloves and perform hand hygiene.