STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395745	A. Building B. Wing	06/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Baldwin Health Center	1717 Skyline Drive Pittsburgh, PA 15227

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39311 Based on facility policy, observations and resident and staff interviews, it was determined that the facility failed to maintain a clean, comfortable environment on three of four nursing units observed (A, B, and D wing nursing unit). Findings include: Review of facility policy, Resident Rights, dated 4/5/21, indicated that the facility will provide safe housing and will attend to resident needs. During observations of the D wing nursing unit on 5/25/21, from 10:30 a.m. until 12:40 p.m. the following was observed: Floor in the D wing lounge/dining room was soiled and sticky. Floor in Resident R500's room (D wing) was noted to be sticky and urine odors were apparent, soiled clothing was piled on the heating unit and there was debris on the floor. Resident R501's room (D wing) was noted to have very strong urine odor able to be detected from the hallway. Resident R502's room (C wing) strong urine odor able to be detected from the hallway. Floors had grime buildup along the walls in most places on the D wing unit. During an interview on 5/25/21, at 12:40 p.m. Unit Manager Employee E3 confirmed the observations. During observations on 5/26/21, 5/27/21, 5/28/21, 6/2/21 and 6/3/21, Residents R503 and R504's rooms continued to have very strong urine odors. During an interview on 6/3/21, at 1:30 p.m., Unit Manager Employee E3 confirmed the presence of the urine odors. (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R92's admission record indicated he was admitted to the facility on [DATE]. A review of the quarterly Minimum Data Set assessment (MDS - periodic assessment of care needs) dated 5/2/21, included diagnoses of high blood pressure and muscle weakness. During an observation on 5/31/21, at 2:10 p.m. a soiled brief was laying on the dresser next to Resident R92's bed. Disposable cleansing wipes were left on top of the soiled brief. During an interview on 5/31/21, at 2:18 p.m. Nurse Aide (NA) Employee E31 confirmed that a soiled brief had been left on the dresser from a previous brief change for Resident R92. Review of Resident R66's admission record indicated he was admitted to the facility on [DATE]. A review of the admission MDS dated [DATE], included diagnoses of quadriplegia (paralysis of all four limbs) and neurogenic bladder (bladder problems due to disease or injury of the nervous system involved in the control of urination). During an observation on 5/31/21, at 9:18 p.m. NA Employee E30 was providing incontinence care to Resident R66. During an observation and interview on 5/31/21, at 9:40 p.m. a soiled brief was observed in the seat of Resident R66's motorized wheelchair. During an interview on 5/31/21, at 11:36 p.m. NA Employee E30 confirmed that he left the soiled brief in Resident R66's wheelchair. Review of Resident R153's admission record indicated she was admitted to the facility on [DATE]. A review of the quarterly MDS dated [DATE], included diagnoses of diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time) and spinal stenosis (a condition where spinal column narrows and compresses the spinal cord). During an observation and interview on 5/31/21, at 9:20 a.m. the observation revealed that four wet, soiled towels were left on the floor in the entryway to Resident R153's room and the garbage can was overflowing with refuse on the floor around it. During an interview on 6/3/21, at 1:30 p.m. the Director of Nursing confirmed the facility failed to provide a clean environment and attend to residents' needs. 28 Pa. Code: 207.2 Administrator's responsibility.

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26071 Based on facility policy and clinical record review and interview with facility staff, it was determined that the facility failed to obtain a physician order and send all appropriate clinical documentation for residents transferred to an acute care facility for three of four residents reviewed (Resident R36, R50, and R341). Findings include: A review of the facility policy, Transfer and Discharge, reviewed 4/5/21, indicated the facility will meet the needs of the resident for a smooth transfer or discharge. The physician will be notified, and necessary information will be provided to the receiving provider to include at a minimum, contact information of the provider, resident representative information, advanced directive information, instructions for ongoing care, comprehensive care plan, and any other information applicable to ensure a safe and effective transmission. A review of the clinical record indicated Resident R36 was admitted to the facility on [DATE], with diagnoses that included dementia with behaviors. A review of the quarterly Minimum Data Set assessment (MDS - a periodic assessment of resident care needs) dated 2/10/21, indicated the diagnoses remained current. A review of a nurse progress note dated 3/9/21, indicated the resident was sent to the hospital for a psychiatric evaluation on 3/8/21, and returned to the facility the same day. The clinical record did not include a physician order or evidence of required transfer documentation sent to the receiving acute care facility on 3/8/21. A review of the clinical record indicated Resident R50 was admitted to the facility on [DATE], with diagnoses that included quadriplegia (paralysis form the neck down) and neurogenic bladder (disfunction of nerves between the bladder and spinal cord). A review of the quarterly MDS dated [DATE], indicated the diagnoses remain current, the resident is alert and oriented, is usually understood and understands. During an observation on 5/25/21, at 12:45 p.m. Resident R50 was observed being taken to the hospital on a stretcher accompanied by two ambulance attendants. A review of a physician order dated 5/26/21, indicated the resident went to the hospital and had a supra pubic catheter (a tube placed into the bladder form an incision into the lower abdomen) placed. A review of a nurse note dated 5/26/21, indicated the resident was in the facility alert and oriented, stable, and indwelling catheter intact and patent. During an interview on 5/27/21, at 7:00 p.m. Resident R50 stated, I went to the hospital because my catheter was leaking and needed to be replaced. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The clinical record did not include a physician order or evidence of required transfer documentation sent to the receiving acute care facility on 5/25/21. A review of the clinical record indicated Resident R341 was admitted to the facility on [DATE], with diagnoses that included dementia with behaviors and bipolar disorder. A review of a nurse progress note dated 3/11/21, indicated the resident was discharged to the hospital on 3/11/21, due to an increase in aggressive behaviors. The clinical record did not include a physician order or evidence of required transfer documentation sent to the receiving acute care facility on 3/11/21. During an interview on 6/2/21, at 11:55 a.m. the Director of Nursing (DON) revealed that a transfer sheet must be filled out and sent with the resident when discharged to an acute care facility. The DON confirmed the above findings and the facility failed to obtain a physician order and send required clinical documentation during transfer of residents R36, R50, and R341. 28 PA Code 201.18(b)(1)(2) Management Previously cited 9/10/20, 3/22/21. 28 PA Code: 201.25 Discharge Policy. 28 PA Code: 211.5(d) (f) Clinical Records.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 19330 Based on observation, review of clinical records and staff interview, it was determined that the facility failed to ensure that dependent residents received showers for six of 46 residents reviewed (Resident R48, R62, R90, R112, R121 and R173). Findings include: The facility policy entitled, Routine Resident Care, dated 4/5/21, indicated that licensed staff will include the following services: monitoring and assessment of resident needs, routine care is provided by Nurse Aides assisting or provides for personal care such as bathing, dressing, eating and hydration and toileting. Review of the clinical face sheet indicated that Resident R62 was admitted to the facility on [DATE], with diagnosis that included chronic venous insufficiency of lower extremities, morbid obesity and sleep apnea. Review of the quarterly Minimum Data Set assessment (MDS - periodic assessment of care needs) dated 5/19/21, indicated that Resident R62 was totally dependent on staff for toileting, bathing and personal hygiene. Review of Resident R62's Care Plan dated 4/21/21, indicated that she needs extensive assistance for personal hygiene and bathing. Review of the Shower Assignment Sheet indicated that Resident R62 was to be showered on Tuesday and Friday on the 7:00 a.m. to 3:00 p.m. shift. Review of nurse aide documentation on 6/2/21, revealed that the Resident R62 had received bed baths but no showers during the past 30 days. During an observation on 5/25/21, at 9:40 a.m. Resident R62 was noted to have poor hygiene and body odors. Review of the clinical face sheet indicated that Resident R48 was admitted to the facility on [DATE], with diagnosis that included acute renal failure, rhabdomyolysis (muscle damage) and schizophrenia (inability to discern reality). Review of the MDS dated [DATE], indicated that Resident R48 was totally dependent on staff for bathing and personal hygiene. Review of Resident R48's Care Plan dated 6/1/21, indicated that he needs extensive assistance for personal hygiene and bathing. Review of the Shower Assignment Sheet indicated that Resident R48 was to be showered on Monday and Thursday on the 11:00 p.m. to 7:00 a.m. shift. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of nurse aide documentation revealed that Resident R48 had received bed baths but no showers during the past 30 days. During an observation on 5/25/21, at 10:10 a.m. Resident R48 was noted to have poor hygiene and body odor. Review of the clinical face sheet indicated that Resident R173 was admitted to the facility on [DATE], with diagnosis that included stroke with left sided weakness, contractures of both hips and left knee and debility. Review of the MDS dated [DATE], indicated that Resident R173 was totally dependent on staff for toileting and bathing and extensive assistance required for personal hygiene. Review of Resident R173's Care Plan dated 5/27/21, indicated that he needs extensive assistance for personal hygiene and is totally dependent for bathing. Review of the Shower Assignment Sheet indicated that Resident R173 was to be showered on Monday and Thursday on the 7:00 a.m. to 3:00 p.m. shift. Review of nurse aide documentation revealed that Resident R173 had received bed baths but no showers during the past 30 days. During an observation on 5/25/21, at 10:00 a.m., Resident 173 was noted to have poor hygiene, body odor and was unshaven. Review of the clinical face sheet indicated that Resident R112 was admitted to the facility on [DATE], with diagnosis that included Alzheimer's disease, cognitive communication deficit and failure to thrive. Review of the MDS dated [DATE], indicated that Resident R112 was totally dependent on staff for toileting, bathing and personal hygiene. Review of Resident R112's Care Plan dated 5/17/21, indicated that she needs extensive assistance for personal hygiene and is totally dependent for bathing. Review of the Shower Assignment Sheet indicated that Resident R112 was to be showered on Monday and Thursday on the 7:00 a.m. to 3:00 p.m. shift. Review of nurse aide documentation revealed that Resident R112 had received bed baths but no showers during the past 30 days. Review of the clinical face sheet indicated that Resident R121 was admitted to the facility on [DATE], with diagnosis that included schizophrenia, diabetes and cognitive communication deficit. Review of the MDS dated [DATE], indicated that Resident R121 was totally dependent on staff for toileting, bathing and personal hygiene. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Shower Assignment Sheet indicated that Resident R121 was to be showered on Tuesday and Friday on the 7:00 a.m. to 3:00 p.m. shift. Review of nurse aide documentation revealed that Resident R121 had not received bed baths or showers during the past 30 days. Review of the clinical face sheet indicated that Resident R90 was admitted to the facility on [DATE], with diagnosis that included Parkinson's disease (neuromuscular disorder causing tremors and difficulty walking. Review of the MDS dated [DATE], indicated that Resident R90 was totally dependent on staff for toileting, bathing and personal hygiene. Review of the Shower Assignment Sheet indicated that Resident R90 was to be showered on Tuesday and Friday on the 7:00 a.m. to 3:00 p.m. shift. Review of nurse aide documentation revealed that Resident R90 had received bed baths but no showers during the past 30 days. During an interview on 6/2/21, at 1:30 p.m. the C/D Wing Unit Manager Employee E3 confirmed that showers were not always being done due to nursing staffing issues Refer to F677. 28 Pa Code 211.12 (a)(c) Nursing services 28 Pa Code 201.29(a)(j) Resident rights

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19330 Based on facility policy and clinical record review, and staff interview, it was determined that the facility failed to provide medications as ordered by the physician for one of 20 residents (Resident R84), failed to provide wound care as ordered by the physician for two of 14 residents (Resident R62 and R93), failed to provide catheter care as ordered by the physician for one of four residents (Resident R147), failed to provide services for four of 11 residents receiving hospice (Residents R61, R139, R155, and R171), failed to follow physician orders to obtain weights for three of five residents (Residents R183, R139, and R186) and failed to obtain a physician order for two of 16 residents with IV (intravenous) access devices, (Residents R92 and R168). Findings include: A review of the facility policy, Medication Administration, dated 4/5/21, indicated medication is administered as prescribed by the provider. A review of the facility policy, Physician Orders, dated 4/5/21, indicated that physician orders will be executed by licensed nursing staff. A review of the clinical record indicated Resident R84 was admitted to the facility on [DATE], with diagnoses that included heart disease, nerve pain, and dizziness. A review of a physician order dated 4/20/21, indicated to give Meclizine (antihistamine used to treat motion sickness and dizziness) 25 mg (milligrams) three times a day by mouth at 09:00, 17:00, and 21:00. A review of the medication administration record (MAR) dated May 2021, indicated Resident R84 did not receive meclizine on 5/2/21 at 17:00, 5/3/21 at 09:00, and 5/26/21 at 17:00 and 21:00. A review of a nurse progress notes dated 5/2/21, indicated the Meclizine was re-ordered, on 5/3/21 the Meclizine, did not arrive from the pharmacy, and on 5/26/21 the Meclizine was, on order. During an interview on 6/1/21, at 12:55 p.m. the Director of Nursing (DON) confirmed the above findings and the facility failed to provide medication as ordered by the physician for Resident R84. A review of the clinical face sheet indicated that Resident R61 was admitted to the facility on [DATE], and the MDS dated [DATE], confirm diagnoses include malignant (tumors/cells that spread and grow uncontrollably) cancer of the colon, bladder, and prostate, cirrhosis (chronic damage leading to scarring and failure) of the liver, urinary tract infection (infection in any part of the kidneys, bladder or urethra) colostomy (surgery to divert the colon into an artificial opening in the abdominal wall for waste elimination), and adult failure to thrive (seen in older adults with multiple medical conditions resulting in downward spiral of poor nutrition, weight loss, inactivity, depression and decrease in functional abilities). A review of the physician order dated 3/9/21, indicated consult and treat to hospice. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/27/21, at 9:55 p.m. the DON confirmed that the facility failed to obtain a physician order for hospice services, diagnosis for treatment and the hospice service provider. A review of the clinical record indicated that Resident R93 was admitted to the facility on [DATE], and the quarterly MDS dated [DATE], confirm diagnoses of alcohol induced dementia (brain damage related to excessive alcohol use), anxiety disorder (mental health disorder consisting of feelings of worry and fear that interfere with one's daily activities), skin cancer of nose, and schizoaffective disorder, bipolar type (a combination disorder of delusions and paranoia with mania or great excitement and overactivity). A review of the physcian order dated 5/18/21, indicated that the left toe wound is to be cleansed, Medihoney and a dry dressing applied every day on the daylight shift. During an observation on 5/25/21, at 11:20 a.m. of Resident 93's foot dressing revealed the date 5/21/21. During an interview on 5/25/21, at 11:20 a.m. ADON Employee E16 confirmed that the facility failed to provide wound care as ordered by the physician for Resident R93. A review of the clinical record indicated that Resident R139 was admitted to the facility on [DATE], and the admission MDS dated [DATE], confirm diagnoses included A review of the clinical face sheet indicated that Resident R139 was admitted to the facility on [DATE]/21, and the admission MDS dated [DATE], confirmed diagnoses diabetes (a metabolic disorder in which the body has high sugar levels for prolonged periods of time) and dementia (mental disorder with memory loss and other cognitive changes). MDS Section O: Special Treatments, Procedures, and Programs indicated that Resident R139 received hospice services prior to admission, and was currently receiving hospice services while in the facility. A review of the physician order for Resident R139 current on 5/26/21, failed to reveal an order for hospice services. A review of the clinical face sheet indicated that Resident R155 was admitted to the facility on [DATE], and the admission MDS dated [DATE], confirmed diagnoses included diabetes and adult failure to thrive. MDS Section O: Special Treatments, Procedures, and Programs indicated that Resident R155 received hospice services prior to admission, and was currently receiving hospice services while in the facility. A review of the physician order for Resident R155 current on 5/26/21, failed to reveal an order for hospice services. A review of the clinical face sheet indicated that Resident R171 was admitted to the facility on [DATE], and the annual MDS dated [DATE], confirmed diagnoses included hemiplegia (paralysis on one side of the body) and diabetes. MDS Section O: Special Treatments, Procedures, and Programs indicated that Resident R139 received hospice services while in the facility. A review of the physician order dated 4/29/20, indicated to refer to hospice. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/27/21, at 9:55 p.m. the DON confirmed that the facility failed to obtain a physician order for hospice services, diagnosis for treatment and the hospice service provider for Residents R61, R139, R155, and R171. A review of the clinical record indicated Resident R186 was admitted to the facility on [DATE], with diagnoses that included dementia, schizophrenia (mental disorder that causes hallucinations), and heart disease. A review of a physician order dated 5/3/21, indicated to obtain weekly weights. A review of the medication administration record (MAR) dated May 2021, indicated weights were not obtained on 5/10, 5/17, 5/24, and 5/31/21. During an interview on 6/1/21, at 12:55 p.m. the DON confirmed the above findings and the facility failed to follow a physician order for weekly weights for Resident R186. A review of the clinical face sheet indicated that Resident R155 was admitted to the facility on [DATE], and the admission MDS dated [DATE], confirmed diagnoses included diabetes and adult failure to thrive. A review of a physician order dated 5/10/21, indicated to obtain weekly weights. A review of the clinical record, Weight Summary failed to indicate any weights taken on Resident R139 until 6/3/21, when it was done at surveyor request. During an interview on 6/3/21, at 1:30 p.m. the DON confirmed the above findings and the facility failed to follow a physician order for weekly weights for Resident R139. A review of the clinical record indicated that Resident R92 was readmitted to the facility on [DATE]. A review of the admission MDS dated [DATE], included diagnoses of bipolar disorder (mental illness characterized by extreme mood swings) and high blood pressure. A review of the clinical admission evaluation dated 4/16/21, revealed that Resident R92 had a PICC line (peripherally inserted central catheter for long term use of IV antibiotics, nutrition, or medications) placed in his left upper arm. An observation on 5/25/21, at 11:15 a.m. revealed Resident R92 did not have a PICC in place. A review of physician orders on 5/26/21, did not include an order on the care plan of the PICC line, or an order to remove the PICC line. No subsequent nursing notes indicated the presence, care, or removal of the PICC line. During an interview on 6/3/21, at 1:30 p.m. the DON confirmed that the facility failed to obtain a physician order to care for or remove R92's PICC line. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the clinical record indicated that Resident R168 was admitted to the facility on [DATE], with diagnoses that included spastic diplegic cerebral palsy (birth injury affecting the legs causing knees to turn in and cross due to tightness of hip and leg muscles), hypertension (high blood pressure), urine retention (difficulty urinating or completely emptying the bladder), urinary tract infection (infection in any part of the urinary system of kidneys, bladder or urethra), and iron deficiency anemia (too little iron in the body causing fatigue). A review of the quarterly MDS dated [DATE], indicated a Brief Interview of Mental Status (BIMS) score of 5 indicating severe cognitive impairment. A review of a progress note dated 5/22/21, indicated that Resident R168 had pulled out the PICC line from his right arm. The IV team was called, obtained consent from the resident, and placed a new PICC line in his left arm. A review of the physician orders did not include an order to replace the PICC line. During an interview on 6/3/21, at 10:39 a.m. the DON confirmed that the facility failed to obtain a physician order to replace R168's PICC line to continue treatment of IV antibiotics. 28 Pa. Code: 201.14(a) Responsibility of licensee. Previously cited 5/28/19, 8/16/19, 9/10/20, 1/15/21, 3/22/21. 28 Pa. Code: 201.18(a)(b)(3) Management. Previously cited 5/28/19, 8/16/19, 9/10/20, 1/15/21, 3/22/21. 28 Pa. Code: 211.12 (d)(1)(3)(5) Nursing services. Previously cited 5/28/19, 7/1/19, 8/16/19, 9/10/20, 1/2/21, 1/15/21, 3/22/21. 28 Pa. Code: 211.12(d)(1)(5) Nursing services. Previously cited 3/22/21, 7/1/19.

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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 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39311 Based on facility documents, observations, and resident and staff interviews, it was determined that the facility failed to have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for residents; failed to ensure that dependent residents received showers for six of 46 residents reviewed (Resident R48, R62, R90, R112, R121 and R173); failed to make certain that seven of 11 residents were monitored, assessed, and received the necessary services to prevent pressure ulcers from developing or worsening (Residents R78, R93, R114, R130, R120, R164, and R183), and failed to prevent pressure ulcer development resulting in actual harm for one of 17 residents reviewed (Resident R117). Additionally, the facility failed to provide feeding assistance as ordered for one of four residents reviewed with weight loss (Resident R48), failed to obtain a physician order for a urinary catheter (tube inserted to remove urine), provide care for a resident with a catheter, and assess a resident for removal of a catheter for four of 20 residents reviewed (Resident R50, R113, R168 and R340), and to provide care and services to maintain bladder continence in one of five residents reviewed (Resident R62), and placed the facility in an Immediate Jeopardy situation for 29 of 45 residents reviewed (Resident R93, R78, R48, R90, R121, R112, R113, R173, R114, R62, R116, R50, R84, R130, R136, R120, R164, R168, R183, R80, R117, R160, R179, R99, R47, R20, R24, R27, and R340). Findings include: Review of the Facility assessment dated [DATE], indicated the facility will have sufficient staff to meet the needs of the residents at any given time. Review of the facility policy Nurse Staffing Information dated 4/5/21, indicated the facility will provide the sufficient number of staff to care for the resident population. Review of the facility policy, Routine Resident Care dated 4/5/21, indicated that the facility will provide personal care including bathing, dressing, eating and hydration, toileting, assisting with ambulation, transfer, and repositioning. During an initial tour and resident interviews of the C wing nursing unit on 5/25/21, at 9:40 a.m. Resident R112 indicated that her brief was wet, she wanted to be changed, and a strong urine odor was detected. During an initial tour and resident interview on 5/27/21, at 9:21 a.m. Resident R114 stated, Are you here to change me? and that her call light sometimes does not get answered for a couple hours. Resident R114 was visibly wet and stated, I haven't been changed since last night. During an observation on 5/25/21, at 9:50 a.m. Resident R173 was noted to have an obviously wet brief and bed sheet, urine odor was detected, and the resident stated no one is coming to change me and I've been laying in urine all day. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an initial tour of the B wing nursing unit on 5/25/21, at 10:00 a.m. Resident R116 indicated the call bell has been on since 7:00 a.m. and no one comes. Resident R116 needed assistance to the bathroom and stated, I sometimes wear a brief because it takes too long for them to come. A review of the clinical record indicated Resident R116 was continent of urine. During an interview on 5/25/21, at 10:15 a.m. Resident R50 indicated it takes hours for the call bell to be answered. Resident 50 stated, I need assistance with eating, and no one comes. Sometimes I lay in my own waste for hours. During a resident interview on 5/25/21, at 10:30 a.m. Resident R84 indicated staff never answer the call bells. Resident R84 stated, I have to wait a very long time to get any assistance at all for anything. During a resident interview on 5/25/21, at 10:45 a.m. Resident R130 indicated that staff do not respond to call bells. Resident R130 stated, I have to wait a long time to get help to go to the bathroom. During a resident interview on 5/25/21, at 10:55 a.m. Resident R136 indicated that there is not enough staff to answer call bells and they never bring water. Resident R136 stated, Even when you ask for water, they don't bring it. I can't wait to get out of here. During a resident interview on 5/25/21, at 11:00 a.m. Resident R120 indicated call bells are not answered timely. Resident R120 stated, I have to wait hours to get out of bed. They never come when you call. During an observation on 5/25/21, at 1:00 p.m. the call light was activated for Resident R80. The lighted monitor at both ends of the hall and facing the nurse station illuminated with the location requesting assistance. Two licensed nurses and one nurse aide were at the nurse's station. During an interview on 5/25/21, at 1:40 p.m. (40 minutes later) with Registered Nurse (RN) charge nurse Employee E42 and Resident R80, the RN Employee E42 confirmed the call bell was not answered timely and the resident indicated that he wanted pulled up in bed. During an observation on 5/25/21, at 1:00 p.m. the call light was activated for Resident R120. The lighted monitor at both ends of the hall and facing the nurse station illuminated with the location requesting assistance. Two licensed nurses were at the nurse's station. During an interview on 5/25/21, at 2:00 p.m. (one hour later) with RN Employee E42 and Resident R120, the RN Employee E42 confirmed the call bell was not answered timely and the resident indicated that he had been waiting to get out of bed. During an observation on 5/25/21, at 1:00 p.m. the call light was activated for Resident R117. The lighted monitor at both ends of the hall and facing the nurse station illuminated with the location requesting assistance. Two licensed nurses were at the nurse's station. During an interview on 5/25/21, at 2:00 p.m. (one hour later) with RN Employee E42 and Resident R117, RN Employee E42 confirmed the call bell was not answered timely and the resident indicated she needed assistance with dialing the telephone. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident R160's admission record indicated she was admitted to the facility on [DATE]. A review of the quarterly Minimum Data Set assessment (MDS - periodic assessment of care needs) dated 5/10/21, included diagnoses of schizophrenia (a mental disorder characterized by delusions, hallucinations, disorganized speech, and behavior), muscle weakness, and difficulty walking. Section G Functional Status indicated that Resident R160 is totally dependent on staff for dressing, transfers in and out of bed, and bathing. Review of Resident R160's plan of care updated 4/27/21, indicated she required dependent assist of two with transfers using a mechanical lift, and extensive assistance of one staff member with dressing and bathing. During an interview and observation on 5/25/21, at 10:15 a.m. Resident R160 was in bed without a shirt or gown on, only a sheet covering her. Resident R160 stated, I would love to be wearing a top, and I'm not. Resident R160 further stated that she is, stuck in bed forever and I don't get enough showers. Review of the ADL Care Look Back Report (a facility generated monthly report of nurse aide documentation for ADL completion) from 4/1/21 through 5/25/21, indicated no showers were provided for Resident R160. Review of Resident R179's admission record indicated she was admitted to the facility on [DATE]. A review of the quarterly MDS dated [DATE], included diagnoses of heart failure and diabetes, and difficulty walking and indicated that Resident R179 had moderate cognitive impairment. During an interview on 5/25/21, at 2:05 p.m. Resident R179 stated that staff, sometimes never answer call bell, you have to yell for help, I call them on the phone. Resident R179 stated that if she had dialysis treatments, she didn't always get her meals when she came back and was not bathed on those days. Review of Resident R99's admission record indicated she was admitted to the facility on [DATE]. A review of the annual MDS dated [DATE], included diagnoses of Alzheimer's disease (a type of brain disorder that causes problems with memory, thinking and behavior), high blood pressure, and muscle weakness. Section G: Functional Status, Question G0120 indicated that Resident R99 was totally dependent on staff for toilet use and Section H: Urinary Continence indicated that Resident R99 was always incontinent of urine. Review of Resident R99's plan of care updated 4/20/21, indicated that she was incontinent of bowel and bladder, and for staff to aid with toileting, provide peri-care after each incontinent episode, and change briefs as needed. During an interview on 5/26/21, at 8:00 a.m. Resident Family RF99 indicated, they are very understaffed, and the facility has had staffing problems before but that he had never seen it this bad. RF99 indicated that he comes in every morning and changes his mother's brief, which are often wet. Review of Resident R47's admission record indicated she was admitted to the facility on [DATE]. A review of the quarterly MDS dated [DATE], included diagnoses of Chronic Obstructive Pulmonary Disease (COPD, a group of progressive lung disorders characterized by increasing breathlessness), muscle weakness, and difficulty walking. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an observation on 5/26/21, from 7:45 a.m. until 8:31 a.m. (a period of 46 minutes), the call light signal for Resident R47's room appeared on the announcement screens on the C wing nursing unit. During an interview on 5/26/21, at 8:33 a.m. Resident R47 confirmed that she had been waiting for a response to her call bell, for over a half hour and that they had just answered it. Review of Resident R24's admission record indicated she was admitted to the facility on [DATE]. A review of the quarterly MDS dated [DATE], included diagnoses of Alzheimer's disease, heart failure, and muscle weakness. Section G Functional Status indicated that Resident R24 was totally dependent on staff for transfers and bathing. During an interview on 5/26/21, at 2:15 p.m. Resident Family RF24 stated that she was aware that they are not giving her mother showers, just bed baths and that she is often in bed at 11:00 a.m. even though the resident family member had asked that they shower her and get her up, they don't have enough help. Review of the Shower Assignment Sheet indicated that Resident R24 was to have showers on Tuesday and Friday on the 7:00 a.m. to 3:00 p.m. shift. Review of Resident R114's admission record indicated she was admitted to the facility on [DATE]. A review of the quarterly MDS dated [DATE], included diagnoses of diabetes, muscle weakness, and contractures. During an interview on 5/27/21, at 9:21 a.m. Resident R114 stated that her call light sometimes does not get answered for a couple hours. The resident specifically stated she waited for incontinent care and to get out of bed. Resident has been and has a history of incontinence. Additionally, Resident R114 stated staffing difficulties are more on the weekends. Review of Resident R27's admission record indicated she was admitted to the facility on [DATE]. A review of the annual MDS dated [DATE], included diagnoses of high blood pressure and muscle weakness, difficulty walking, and a BIMS of 15, which indicated the resident was cognitively intact During an interview on 5/27/21, at 9:56 a.m. Resident R27 stated that her call light does not get answered timely, and she often must look for a nurse for assistance. The resident expanded stating that she would need help to get to the bathroom and have incontinent periods two to three times a week when she couldn't make it on her own. Review of Resident R64's admission record indicated she was admitted to the facility on [DATE]. A review of the quarterly MDS dated [DATE], included diagnoses of heart failure, hemiplegia (paralysis on one side of the body), and muscle weakness. Section C: Cognitive Status indicated that Resident R64 had no cognitive impairments and Section G Functional Status indicated that Resident R64 requires staff assistance for transfers, toilet use, and bathing. During an interview on 5/28/21, at 12:47 p.m. Resident R64 stated, I put my call light on one night because my roommate was vomiting and had to get into her wheelchair to go to the desk because no one came. Resident R64 also indicated that showers were not being given because, you need two people to use the lift and they don't have enough staff. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident R117's admission record indicated she was admitted to the facility on [DATE]. A review of the quarterly MDS dated [DATE], included diagnoses of polyosteoarthritis (condition when five or more joints are affected with joint pain) and repeated falls. Section G Functional Status indicated that Resident R117 requires assistance for bathing. A review of Resident R117's plan of care dated 4/15/21, indicated she required physical assistance with bathing. During a family interview on 5/31/21, at 1:37 p.m. Resident R117's daughter stated that she is concerned that her mother is not being, bathed or even wiped down. Daughter stated that on a previous visit a nurse aide had told her that she would be in the room in ten minutes to assist Resident R117 to the restroom but after two hours her daughter assisted her mother herself. Resident R117's son-in-law stated that he has brought up his concerns to the Nursing Home Administrator (NHA), twice previously. During an interview on 5/26/21, at 9:36 a.m. Nurse Aide (NA) Employee E31 stated that she often does not have time to shower people, that sometimes there is only one aide for two floors, and that she would not be able to get any residents who require an assist of two out of bed on this day due to there not being staff available to assist her. Review of the facility provided deployment sheet for 5/26/21, indicated NA Employee E31 was assigned to the first floor. Per the deployment sheet, the census for that unit was 89 residents, with four nurse aides assigned, averaging 22 to 23 residents per nurse aide. The facility policy entitled Routine Resident Care dated 4/5/21, indicated that licensed staff will include the following services: monitoring and assessment of resident needs, routine care is provided by Nurse Aides assisting or provides for personal care such as bathing, dressing, eating and hydration and toileting. Review of the clinical face sheet indicated that Resident R62 was admitted to the facility on [DATE], with diagnosis that included chronic venous insufficiency of lower extremities, morbid obesity, and sleep apnea. Review of the quarterly Minimum Data Set (MDS - periodic assessment of care needs) dated 5/19/21, indicated that Resident R62 was totally dependent on staff for toileting, bathing, and personal hygiene. Review of Resident R62's Care Plan dated 4/21/21, indicated that she needed extensive assistance for personal hygiene and bathing. Review of the Shower Assignment Sheet indicated that Resident R62 was to be showered on Tuesday and Friday on the 7:00 a.m. to 3:00 p.m. shift. Review of nurse aide documentation on 6/2/21, revealed that Resident R62 had received bed baths but no showers during the past 30 days. During an observation on 5/25/21, at 9:40 a.m., Resident R62 was noted to have greasy hair and body odors. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the clinical face sheet indicated that Resident R48 was admitted to the facility on [DATE], with diagnosis that included acute renal failure, rhabdomyolysis (muscle damage) and schizophrenia (inability to discern reality). Review of the MDS dated [DATE], indicated that Resident R48 was totally dependent on staff for bathing and personal hygiene. Review of Resident R48's Care Plan dated 6/1/21, indicated that he needed extensive assistance for personal hygiene and bathing. Review of the Shower Assignment Sheet indicated that Resident R48 was to be showered on Monday and Thursday on the 11:00 p.m. to 7:00 a.m. shift. Review of nurse aide documentation revealed that Resident R48 had received bed baths but no showers during the past 30 days. During an observation on 5/25/21 at 10:10 a.m., Resident R48 was noted to be unshaven, hair was not groomed, and had body odor. Review of the clinical face sheet indicated that Resident R173 was admitted to the facility on [DATE], with diagnosis that included stroke with left sided weakness, contractures of both hips, and left knee and debility. Review of the MDS dated [DATE], indicated that Resident R173 was totally dependent on staff for toileting and bathing and extensive assistance required for personal hygiene. Review of Resident R173's Care Plan dated 5/27/21, indicated that he needed extensive assistance for personal hygiene and was totally dependent for bathing. Review of the Shower Assignment Sheet indicated that Resident R173 was to be showered on Monday and Thursday on the 7:00 a.m. to 3:00 p.m. shift. Review of nurse aide documentation revealed that Resident R173 had received bed baths but no showers during the past 30 days. During an observation on 5/25/21, at 10:00 a.m. Resident 173 was noted to have poor hygiene, body odor, and was unshaven. Review of the clinical face sheet indicated that Resident R112 was admitted to the facility on [DATE], with diagnosis that included Alzheimer's disease, cognitive communication deficit, and failure to thrive. Review of the MDS dated [DATE], indicated that Resident R112 was totally dependent on staff for toileting, bathing, and personal hygiene. Review of Resident R112's Care Plan dated 5/17/21, indicated that she needed extensive assistance for personal hygiene and is totally dependent for bathing. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the Shower Assignment Sheet indicated that Resident R112 was to be showered on Monday and Thursday on the 7:00 a.m. to 3:00 p.m. shift. Review of nurse aide documentation revealed that Resident R112 had received bed baths but no showers during the past 30 days. Review of the clinical face sheet indicated that Resident R121 was admitted to the facility on [DATE], with diagnosis that included schizophrenia, diabetes, and cognitive communication deficit. Review of the MDS dated [DATE], indicated that Resident R121 was totally dependent on staff for toileting, bathing, and personal hygiene. Review of the Shower Assignment Sheet indicated that Resident R121 was to be showered on Tuesday and Friday on the 7:00 a.m. to 3:00 p.m. shift. Review of nurse aide documentation revealed that Resident R121 had not received bed baths or showers during the past 30 days. Review of the clinical face sheet indicated that Resident R90 was admitted to the facility on [DATE], with diagnosis that included Parkinson's disease (neuromuscular disorder causing tremors and difficulty walking). Review of the MDS dated [DATE], indicated that Resident R90 was totally dependent on staff for toileting, bathing, and personal hygiene. Review of the Shower Assignment Sheet indicated that Resident R90 was to be showered on Tuesday and Friday on the 7:00 a.m. to 3:00 p.m. shift. Review of nurse aide documentation revealed that Resident R90 had received bed baths but no showers during the past 30 days. During an interview on 6/2/21, at 1:30 p.m., the C/D Wing Unit Manager Employee E3 confirmed that showers were not always being done due to nursing staffing issues. A review of the facility policy Resident Weight dated 4/5/21, indicated that weight loss concerns will be discussed at weekly clinical meetings. A review of the facility policy Routine Resident Care dated 4/5/21, indicated that routine care by Nurse Aides includes assisting with personal care for eating and hydration. A review of the clinical face sheet indicated that Resident R48 was admitted to the facility on [DATE], with diagnosis that included metabolic encephalopathy (mental decline due to disease), bladder infection, kidney failure, and schizophrenia (inability to discern reality). (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A review of the facility policy Skin and Wound Management reviewed 4/5/21, indicated the facility strives to prevent skin impairment and promote the healing of existing wounds. The facility will implement interventions to prevent and treat potential skin integrity issues. Each resident is evaluated upon admission and weekly thereafter for changes in skin condition. The facility will obtain a physician order for appropriate treatment and document on the Treatment Administration Record (TAR). A review of the clinical record indicated Resident R78 was admitted to the facility on [DATE], with diagnoses that included diabetes (a disease in which the body's ability to produce or respond to the hormone insulin is impaired), PVD (peripheral vascular disease-circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), and heart disease. A review of the quarterly Minimum Data Set assessment (MDS - a periodic assessment of resident care needs) dated 3/12/21, indicated the diagnoses remained current. A review of the Wound Evaluation and Management Summary dated 4/7/21, indicated a Stage 3 (full thickness tissue loss, fat may be visible) to the right ischium (hip) measuring 7.0 cm (centimeters) (length) X 7.0 cm (width) X 0.2 cm (depth). A review of a physician order dated 4/8/21, indicated to cleanse the right hip with NSS (normal saline solution) apply leptospermum honey (medical grade honey used in wound healing) and calcium alginate (an absorbent wound dressing that maintains a moist environment for healing) cover with gauze border dressing (an adhesive dressing cover) once daily and as needed. A review of the TAR dated April 2021, indicated the dressing to the right hip was not completed on 4/11, 4/12, and 4/21/21. A review of a physician order dated 4/29/21, indicated to cleanse the right hip with Dakin's half strength solution (an antiseptic solution used to clean wounds) pack with Dakin's soaked gauze and cover with ABD (abdominal) pad (an absorbent dressing cover) two times a day and as needed. A review of the TAR dated May 2021, indicated the dressing to the right hip was not completed on 5/5/, 5/7, 5/11, and 5/23/21. A review of the, Wound Evaluation sheet dated 5/26/21, indicated the wound to the right hip was worsening. A review of the clinical record indicated that Resident R93 was admitted to the facility on [DATE], and the quarterly MDS dated [DATE], revealed diagnoses of alcohol induced dementia (brain damage related to excessive alcohol use), anxiety disorder (mental health disorder consisting of feelings of worry and fear that interfere with one's daily activities), skin cancer of the nose, and schizoaffective disorder, bipolar type (a combination disorder of delusions and paranoia with mania or great excitement and overactivity). The MDS dated [DATE], 5/2/21 and 5/25/21, Section G0110-Activities of Daily Living revealed that the resident requires the extensive assistance of one person for these tasks which includes dressing and personal hygiene. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A review of the Skin Grid Pressure Report dated 5/18/21, revealed a non-stageable area to the left second toe measuring 4 cm by 2.5 cm by 0.2 cm with 100% slough/eschar (yellow moist tissue/dry, black collection of dead tissue). The area was noted after removing the resident's shoes and revealing that the resident was not wearing any socks. A review of a wound consult and X-ray of 5/19/21, indicated cellulitis (an infection under the skin) and Doxycycline (an antibiotic) was ordered for ten days. Treatment ordered to area was Medihoney (works to bring fluid from deeper tissue to promote the removal of dead tissue) and cover area with a dry dressing every day on the daylight shift. An observation on 5/25/21, at 10:35 a.m. of Resident R93's left foot, revealed a dressing dated 5/21/21. ADON Employee E16 was present for the observation and confirmed that the facility failed to ensure pressure ulcers were monitored, assessed, and received the necessary services to prevent ulcers from worsening. There was no explanation as to why the dressing was not done. On 5/26/21, the wound measured 0.7 cm by 0.96 cm by 0.2 cm with 50% granulation tissue and 50% slough/eschar. A review of the clinical record indicated that Resident R114 was admitted to the facility on [DATE], with diagnoses that include cellulitis (inflammation of subcutaneous connective tissue) of the left and right lower limb, type 2 Diabetes Mellitus (a chronic condition that affects the way the body processes blood sugar) with other circulatory complications, hypertensive heart disease, venous insufficiency (improper functioning of the vein valves in the leg causing swelling and skin changes), sepsis (a serious condition resulting from the presence of harmful microorganisms in the blood or other tissues and the body's response to their presence, potentially leading to the malfunctioning of various organs, shock, and death), and Chronic Obstructive Pulmonary Disease (a condition involving constriction of the air ways and difficulty or discomfort in breathing). The current MDS, dated [DATE], confirmed the above diagnoses. A review of a physician order dated 4/5/2021, indicated off-loading boots (therapeutic shoes designed to provide pressure redistribution for patients at risk for diabetic foot conditions such as neuropathic ulcers) while in bed. A review of the care plan, updated 2/12/2021, indicated the resident should use an appropriate offloading mattress (a mattress to redistribute a patient's weight so to relieve pressure points). Observations on 5/26/21, 5/27/21, 5/28/21, 6/1/21, 6/2/21, and 6/3/21, revealed that Resident R114 was not wearing off-loading boots while in bed. During an interview on 6/1/21, with Registered Nurse (RN), Employee E34 confirmed that Resident R114 should have off-loading boots on, and they were not in place. RN Employee E34 was unable to give a reason why boots were off. A review of the clinical record indicated Resident R120 was admitted to the facility on [DATE], with diagnoses that included epilepsy (seizure disorder), lymphedema (accumulation of fluid in lower extremities), muscle weakness, and neurological bladder dysfunction requiring use of a urinary catheter. A review of the quarterly MDS dated [DATE], indicated the diagnoses remained current. A review of the Wound Evaluation and Management Summary dated 5/20/21, indicated that Resident R120 had a Stage 3 pressure ulcer to the right posterior thigh measuring 7.4 cm X 3.68 cm X 0 cm that developed on 3/30/21. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A review of physician order dated 2/4/21, indicated to use a low air loss mattress (specialty mattress to prevent pressure ulcer development). An observation on 5/28/21, at 12:25 p.m. revealed that Resident R120's bed did not have a low air loss mattress applied. During an interview on 5/28/21, at 12:35 p.m. Licensed Practical Nurse (LPN), Employee E20 confirmed that Resident R120's bed did not have a low air mattress. During an interview on 5/28/21, at 1:10 p.m. the Director of Nursing (DON) confirmed that the facility staff failed to follow physician orders for a low air loss mattress to prevent further skin breakdown. A review of the clinical record indicated Resident R130 was admitted to the facility on [DATE], with diagnoses that included left BKA (below the knee) amputation, heart disease, and PVD. A review of the quarterly MDS dated [DATE], indicated the diagnoses remained current. A review of a nurse progress noted dated 5/13/21, indicated Resident R130 had 2 open areas to the left leg measuring 1.4 cm X 3.5 cm X 0.0 cm. A review of the Wound Evaluation sheet dated 5/19/21, indicated the left lower leg with Stage 3 pressure ulcer measuring 2.1 cm X 1.78 cm X 0.10 cm. A review of a physician order dated 5/1/21, indicated weekly skin evaluations were to be done by a licensed nurse. A review of the TAR dated May 2021, indicated the scheduled weekly skin evaluation was not completed for the week of 5/1/21 through 5/7/21. A review of a physician order dated 5/14/21, indicated to cleanse the left BKA with NSS, apply hydrogel (a dressing to keep the wound moist), ABD pad and wrap with Kerlix (woven gauze dressing) once daily and as needed. A review of the TAR dated May 2021, indicated the dressing to the left BKA was not completed 5/15/21 through 5/19/21 a total of 5 days. A review of a physician order dated 5/20/21, indicated cleanse left BKA with NSS, apply Medihoney and calcium alginate, cover with ABD, and wrap with Kerlix once daily and as needed. A review of the TAR dated May 2021, indicated the dressing to the left BKA was not completed 5/20/21 through 5/31/21, a total of 12 days. A review of the clinical record indicated Resident R164 was admitted to the facility on [DATE]. A review of the quarterly MDS dated [DATE], included diagnoses of high blood pressure and obstructive uropathy (condition where urine cannot drain through the urinary tract). Review of Section G: Activities of Daily Living (ADL) Assistance indicated that Resident R164 required extensive assistance for bed mobility. Review of Section M: Skin Conditions indicated that Resident R164 was at risk for pressure ulcer development but had no current pressure ulcers at the time of assessment. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395745	A. Building B. Wing	06/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Baldwin Health Center	1717 Skyline Drive Pittsburgh, PA 15227

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A review of the Admission Observation Tool (a screening tool utilized during readmission after a hospitalization) completed by RN Employee E34 on 1/12/21, at 10:28 p.m. indicated that Resident R164 had no current skin conditions. A review of the Braden Observation Tool (a screening tool to assess she vulnerability to pressure ulcer development) dated 2/3/21, indicated that Resident R164 was at low risk of pressure ulcer development. A review of the plan of care updated 3/19/21, indicated the resident required the assistance of two staff to reposition and turn in bed. A review of a physician order dated 2/14/21, indicated pressure relieving boots to both feet at all times, while in bed. During observations on 5/30/21, at 2:55 p.m. on 5/31/21, at 12:45 p.m. and on 6/1/21, at 11:48 a.m. Resident R164 was in bed without pressure relieving boots on. A review of the Initial Wound Evaluation dated, 2/24/21 indicated Resident R164 had an unstageable pressure wound to the right heel measuring 1.5 cm x 3.0 cm x UTD (unable to determine) cm, with a developed date of 2/13/21, and a unstageable pressure wound (a full thickness skin, muscle loss with slough/eschar present in the base of the pressure ulcer, preventing you to see the depth of the ulcer) with necrosis (dead tissue) to the left heel measuring 2.5 cm x 4.0 cm x UTD cm, with a developed date of 2/13/21. A review of the Wound Evaluation dated 5/26/21, indicated a right heel pressure wound measuring 1.98 cm x 2.00 cm x 0.00 cm. A review of a physician order dated 4/16/21, through 5/19/21, indicated to cleanse the left heel with normal saline, pat dry, apply leptopspermum honey, and border gauze daily. From 5/20/21 through 5/26/21, the order changed to cleanse with normal saline, pat dry, apply leptospermum honey, pack with packing strips. Cover with border gauze daily. A review of a physician order dated 4/29/21 through 5/26/21, indicated to apply skin prep to discolored area daily. A review of the May 2021, TAR indicated the left heel dressing change was not completed on 5/13/21, 5/15/21, 5/19/21, 5/20/21, 5/21/21, 5/22/21, and 5/27/21, and the left medial heel dressing change was not completed on 5/13/21, 5/20/21, and 5/21/21. During an interview on 6/3/21, at 1:30 p.m. the DON confirmed the above findings and Resident R164 was readmitted without wounds, and the facility failed to identify a new pressure wound, and to apply pressure relieving boots as ordered by the physician. A review of the clinical record indicated Resident R183 was admitted to

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25570 Based on review of facility policy and state exception, and staff interview, it was determined that the facility failed to provide a working call system for resident use to communicate their needs to staff on four of four nursing units (Nursing Units A, B, C, and D). Findings include: The facility policy Resident Rights dated [DATE], indicated that residents will have a method to communicate needs to staff, that call light or bell access will be within reach of the resident as one method to communicate needs to staff. Staff will answer call needs promptly. Any staff within the vicinity will answer a call light and notify the appropriate personnel for care needs that may not be immediately remedied including but not limited to: toileting, medications and medical care. On [DATE], the Department of Health granted the facility a permanent exception to replace the current nurse call signal with a wireless system. Wireless system compliance is only met if the staff who answer resident calls have functioning devices in their possession and are answering calls. During an interview on [DATE], the Maintenance Director Employee E37 confirmed that all of the pagers were removed from service on or before [DATE], and that there is no alert/audible means for a resident to summon help from staff. During a review of the Maintenance Order dated [DATE], revealed an order for a [NAME] Sounding Device, which will adapt the current system in use with an audible sounding device. The order indicated the dates of installation to be [DATE], and 16, 2021. During an interview on [DATE], at 12:18 p.m. the Nursing Home Administrator confirmed that the Department of Health was not notified that there was a change to the wireless call bell system, that the facility is no longer following the permanent exception that was granted on [DATE], and that the facility does not have a working call system for resident use to communicate their needs on all four nursing units (Nursing Units A, B, C, D). Refer to F725. 28 Pa. Code: 205.28 (c) (1) Nurse's station. 28 Pa. Code: 205.67 (j) (k) Electric requirements for existing and new construction.