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	11/15/2024

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

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 31343 Based on review of facility policies, facility provided documents, clinical records and staff interview, it was determined that the facility failed to make certain a resident was free from abuse, neglect or misappropriation of property for two of three residents reviewed (Resident R190 and R400). Findings include: Review of the facility policy Abuse, Neglect and Misappropriation dated 4/18/24, with a previous review date of 8/21/23, indicated that the facility will provide resident centered care and prevent the abuse, mistreatment, or neglect of residents or the misappropriation of their property. Neglect is identified as the failure of the facility or it's employees to provide care or services to a resident that is necessary to avid physical harm, pain, mental anguish or emotional distress. Review of the facility provided documentation dated 8/27/24, indicated that Resident 190's room mate, Resident R119 had stated that Resident R 190 had not been provided care from Nurse Aide Employee E2 on 8/26/24, during the 7:00 a.m., through 3:00 p.m shift. Review of statements obtained during the investigation, Resident R119 was interviewed on 8/26/24 at 4:00 p. m., and stated that she did not believe her room mate received care on the 7-3 shift. Statements from other residents were not provided. The facility investigation indicated they were unable to determine whether the neglect had actually occurred. The investigation indicated that staff were re- educated on abuse. The documentation related to the training did not include Nurse Aide Employee E2. Review of the clinical record indicated that Resident R190 had been admitted to the facility on [DATE], with diagnoses which included encephalopathy, dementia, bacteriuria(bacteria in urine), heart failure, and heart disease. A MDS dated [DATE], indicated the diagnoses remained current. Resident R190 was in isolation due to positive COVID. Review of the facility Documentation Survey Report (the electronic clinical document indicating care provided or the resident) dated August 2024 did not include documentation indicating care had been provided on 8/26/24, until approximately 9:00 p.m., including ADL care, incontinence care, and a bath/ shower. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility provided documentation dated 10/14/24, indicated that Resident R400 reported to social services that Licensed Practical Nurse (LPN) Employee E9 had stretched out her hand causing discomfort when looking for a pill in her hand. Review of the statement written and signed by Resident R400 stated on 10/13/24, LPN Employee E9 was asked if Resident R400's pills were in her food, LPN Employee E9 responded that they have to watch her take her pills. LPN Employee E9 handed her the cup and then after Resident R400 took the meds in the cup, LPN Employee E9 stretched out Resident R400's pointer finger and thumb of her right hand and when Resident R400 said stop, it was painful , it went on as Resident R400 swallowed her pills. Review of the statement from LPN Employee E9 indicated she asked Resident R400 to open her hand and found Bupropion pill and picked up the pill and put it in Resident R400's mouth and watched her swallow it. Review of the clinical record indicated Resident R400 was admitted to the facility on [DATE], with diagnoses which included Diabetes, lung disease, acute pancreatitis, kidney failure, falls and depression. Resident R400 had been found in her apartment by the apartment manager unresponsive. Review of he clinical record indicated that on 10/22/24, Resident R400 was discharged back to her apartment with ACCESS transport to be followed by AHN Home health. During an interview on 11/14/24, at 9:45 a.m., the Director of Nursing confirmed that the facility failed to make certain a resident was free from abuse, neglect or misappropriation of property for two of three residents reviewed (Resident R190 and R400). 28 Pa. Code: 207.2(a) Administrator's responsibility. 28 Pa. Code 201.18(b)(1)(3) Management. 28 Pa. Code 211.10(d) Resident care policies. 28 Pa. Code 211.12(d)(1)(5) Nursing services.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31343 Based on review of facility policy, review of facility incident/accident reports, clinical records, and staff interviews, it was determined that the facility failed to identify and/or investigate and/or report potential abuse and/or neglect for four of five residents (Resident R4, R13, R57 and R116). Findings include: Review of the facility policy Abuse, Neglect and Misappropriation, dated 4/18/24, with a previous review date of 8/21/23, indicated that the facility will provide resident centered care and the intent of the facility is to prevent the abuse, mistreatment or neglect of residents. The accurate and timely identification of any event which would place our residents at risk for potential abuse is the primary concern. Each occurrence of resident incident, bruise, etc., will be identified and reported to the supervisor and investigated immediately. In the event a situation is identified as abuse, neglect, etc., an investigation by the executive leadership will follow. Review of a grievance placed by Resident R4's mother dated 10/28/24, indicated that Resident R4 was sent to an appointment not appropriately dressed and with a bib on. Review of the facility action form dated 10/29/24, indicated that an investigation identified staff had not freshened up Resident R4 before leaving for the appointment. Review of a grievance placed by Resident R13's daughter dated 9/20/24, indicated that Resident R13 was not provided care on 9/17/24. Review of the facility action form dated 9/23/24, indicated that the assigned nurse aide (NA) was caring for another resident and that Resident R13 was provided care by another NA. Review of a grievance placed by Resident R57 dated 6/22/24, indicated staff would not get him out of bed because they had no lift pad. Review of the facility action form dated 6/26/24, indicated that the facility has plenty of lift pads and staff were re-educated in regards to checking laundry other units and in central supply. Review of a grievance placed by Resident R57 dated 8/7/24, indicated resident identified poor customer service. The facility did not indicate what poor service was identified. Review of he facility action form dated 8/7/24, indicated that the facility verbally discussed poor customer service with staff and Relias training was available. Review of a grievance placed by Resident R116 dated 10/21/24, indicated that he had asked his aide to put him into bed about 2:00 p.m., the NA stated she would, but never returned. Review of the facility action form dated 10/21/24, indicated his NA went on break and the nurse put him back into bed. Not his assigned NA. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident R116's MDS dated [DATE], indicated he was a transfer of two with the hoyer lift. Review of Resident R116's plan of care indicated Resident R116 is a transfer of two with a total lift. During an interview on 11//13/24, at 1:58 p.m., the DON confirmed that the facility failed to identify and/or investigate and/or report potential abuse and/or neglect for four of five residents (Resident R4, R13, R57 and R116). 28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.18(b)(1)(3) Management. 28 Pa. Code: 211. 10(d) Resident care policies. 28 Pa. Code: 211.12(d)(3) Nursing services.

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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** 43725 Based on review of facility policy, clinical records, and staff interviews, it was determined that the facility failed to notify physicians of increased and decreased Capillary Blood Glucose (CBG) levels, failed to assess residents for hyperglycemia (high blood glucose) and hypoglycemia (low blood glucose), for three of six residents reviewed (Residents R6, R20, and R72), and failed to document results accurately in blood glucose summary and medication administration record for three of five residents (Residents R52, R69, and R91). Findings include: The Centers for Disease Control defines diabetes as: Diabetes Mellitus is a chronic (long-lasting) health condition that affects how your body turns food into energy. Most of the food you eat is broken down into sugar (also called glucose) and released into your bloodstream. When your blood sugar goes up, it signals your pancreas to release insulin. Insulin acts like a key to let the blood sugar into your body's cells for use as energy. If you have diabetes, your body either doesn't make enough insulin or can't use the insulin it makes as well as it should. When there isn't enough insulin or cells stop responding to insulin, too much blood sugar stays in your bloodstream. Over time, that can cause serious health problems, such as heart disease, vision loss, and kidney disease. Hypoglycemia is a condition that occurs when blood glucose is lower than normal, usually below 70 milligrams per deciliter (mg/dl). If left untreated, hypoglycemia may lead to weakness, confusion, unconsciousness, arrhythmias and even death. People with Diabetes Mellitus may be prescribed injectable insulin to assist in maintaining acceptable levels of CBG's. Hyperglycemia, or high blood glucose, occurs when there is too much sugar in the blood. This happens when your body has too little insulin. Hyperglycemia is blood glucose greater than 125 mg/dL while fasting (not eating for at least eight hours, or a blood glucose greater than 180 mg/dL one to two hours after eating. If you have hyperglycemia and it ' s untreated for long periods of time, you can damage your nerves, blood vessels, tissues and organs. Damage to blood vessels can increase your risk of heart attack and stroke, and nerve damage may also lead to eye damage, kidney damage and non-healing wounds. Review of the facility policy Blood Glucose Point of Care Testing reviewed 4/18/24, indicated the importance of ongoing glucose monitoring is necessary to detect extremes of high and low blood glucose levels to evaluate the effectiveness of the treatment plan. Review of the facility policy Notification of Change in Condition reviewed 4/18/24, revealed the facility is required to have processed in place for notifications of acute changes such as cardio/respiratory failure, choking, and poor glycemic control, falls, onset of delirium, and falls with head injuries or fractures. The attending practitioner is promptly notified of significant changes in condition, and the medical record must reflect the notification, response, and interventions implemented to address the resident's condition. Review of the facility policy Clinical Documentation Standards reviewed 4/18/24, indicated nurses will follow basic standard of practice for documentation including, but not limited to providing a timely and accurate account of resident information in the medical record. Document accurately and truthfully to the best of his/her knowledge. Document the status of the resident including changes. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the clinical record revealed Resident R6 was readmitted to the facility on [DATE], with diagnoses that included diabetes, heart failure (progressive heart disease that affects pumping action of the heart muscles), and depression. Review of the Minimum Data Set (MDS - a mandated assessment of a resident's abilities and care needs) dated 8/23/24, indicated the diagnoses remain current. Review of a physician order dated 2/13/24, revealed hypoglycemia protocol - able to swallow: follow 15/15 rule. Give 15 grams of fast acting carbohydrate for blood sugar less that 70. May repeat in 15 minutes. Review of the clinical record electronic Medication Administration Record (eMAR) revealed that the resident's CBG's were as follows: On 7/2/24, at 7:34 a.m. CBG was noted to be 60. On 10/31/24, at 7:48 a.m. CBG was noted to be 60. Review of the care plan dated 7/21/22, included administer insulin per medical provider;s orders. Observe for effectiveness and side effects. Report abnormal findings to medical provider. Observe for signs and symptoms of hypoglycemia. Obtain blood sugars per orders. Review of Resident's eMAR and clinical progress notes indicated the resident was not assessed for hypoglycemia, the blood glucose was not monitored for effectiveness of treatment, failed to follow interventions of the care plan, failed to follow physician's orders, and the physician was not notified of abnormal results on the above listed dates. Review of the clinical record indicated Resident R20 was readmitted to the facility on [DATE], with diagnoses that included diabetes, dementia (group of symptoms affecting memory, thinking and social abilities), and high blood pressure. Review of the MDS dated [DATE], revealed the diagnoses remain current. Review of a physician's order dated 5/20/24, indicated to monitor for signs and symptoms of hypo/hyperglycemia. Review of the clinical record eMAR revealed that the resident's CBG's were as follows: On 11/2/24, at 8:42 a.m. CBG was noted to be 64. Review of the care plan dated 3/28/23, included administer medications per medical provider;s orders. Observe for effectiveness and side effects. Report abnormal findings to medical provider. Observe for signs and symptoms of hypoglycemia. Obtain blood sugars per orders. Review of Resident's eMAR and clinical progress notes indicated the resident was not assessed for hypoglycemia, the blood glucose was not monitored for effectiveness of treatment, failed to follow interventions of the care plan, failed to follow physician's orders, and the physician was not notified of abnormal results on the above listed dates. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the clinical record revealed Resident R72 was admitted to the facility on [DATE], with diagnoses that included diabetes, dementia, and repeated falls. Review of the MDS dated [DATE], revealed the diagnoses remain current. Review of a physician's order dated 8/30/24, indicated to inject Novolog insulin (fast-acting) per sliding scale before meals. If blood sugar is 341 - 999, inject six units, call MD. Further review of a physician's order dated 9/2/24, indicated to monitor for signs and symptoms of hypo/hyperglycemia. Review of the clinical record eMAR revealed that the resident's CBG's were as follows: On 10/16/24, at 4:25 p.m. CBG was noted to be 359. Review of the care plan dated 3/18/21, included administer medications per medical provider;s orders. Observe for effectiveness and side effects. Report abnormal findings to medical provider. Observe for signs and symptoms of hyperglycemia. Obtain blood sugars per orders. Review of Resident's eMAR and clinical progress notes indicated the resident was not assessed for hypoglycemia, the blood glucose was not monitored for effectiveness of treatment, failed to follow interventions of the care plan, failed to follow physician's orders, and the physician was not notified of abnormal results on the above listed dates. During an interview on 11/13/24, at 12:34 p.m. Licensed Practical Nurse (LPN) Employee E6 stated for blood sugars below 60, they would give juice and snacks, call the doctor, and recheck the blood sugar per doctor's orders. If blood sugar was elevated, they would check the physician's orders for sliding scale parameters. Follow the orders, recheck the blood glucose in 20 minutes and document in the nurses notes. During an interview on 11/13/24, at 12:37 p.m. LPN Employee E3 stated any blood sugar under 70, they would for sure call the doctor, give juice and snack, assess the resident and recheck the blood sugar in 45 minutes. If the blood glucose was elevated, usually around 350 - 400, they would check the physician orders for sliding scale parameters. Call the doctor, and document in the eMAR. During an interview on 11/13/24, at 12:42 p.m. LPN Employee E7 stated anything below 70 or above 400, they would call the doctor. They would follow the received orders and document in the eMAR and nurses notes. During an interview on 11/13/24, at 12:46 p.m. Registered Nurse (RN) Employee E8 stated if blood sugar was between 70-80, they would give juice or snack. They would assess the resident. If blood sugar was greater than 400, they would check the orders for parameters, and call the doctor. They would document in the nurses notes. During an interview on 11/15/24, at 11:00 a.m. the Director of Nursing confirmed the facility failed to document hypo-/hyperglycemic episodes, failed to follow physician orders, and failed to notify the MD of changes in condition for Residents R6, R20, and R72. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the clinical record revealed Resident R52 was admitted to the facility on [DATE], with diagnoses that included diabetes, bilateral below knee amputations, chronic kidney disease(The kidneys filter waste and excess fluid from the blood, as the kidneys fail they no longer filter waste). Review of the MDS dated [DATE], indicated the diagnoses remain current. Review of a physician order dated 10/4/24, revealed Lispro (fast-acting insulin that starts to work about 15 minutes after injection, peaks in about 1 hour, and keeps working for 2 to 4 hours) insulin, 3 units with meals, if blood sugar less than 120 to hold and notify physician. Review of the clinical record eMAR revealed that the resident's CBG's were as follows: On 11/1/24, at 8:01 a.m. CBG was noted to be 81. On 11/12/24, at 7:56 a.m. CBG was noted to be 90. On 11/13/24, at 7:36 a.m. CBG was noted to be 92. Review of Resident's eMAR and clinical progress notes indicated the resident was not assessed for hypoglycemia, the blood glucose was not monitored for effectiveness of treatment, failed to follow interventions of the care plan, and the physician was not notified of abnormal results on the above listed dates. Review of the care plan dated 9/8/24, included diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness, monitor/document/report to MD as needed for signs and symptoms of hypo-/hyperglycemia. Review of the clinical record revealed Resident R69 was admitted to the facility on [DATE], with diagnoses that included diabetes, obesity, and dementia (a group of thinking and social symptoms that interferes with daily functioning). Review of the MDS dated [DATE], indicated the diagnoses remain current. Review of a physician order dated 10/26/23, revealed Novolog insulin sliding scale with result less than 130 to be held. A physician order dated 8/19/22, revealed an order for blood sugars to be checked in early AM every day. Review of the clinical record electronic Medication Administration Record (eMAR) revealed that the resident's CBG's were as follows: On 11/13/24, No results documented for AM glucose or insulin dosage On 11/3/24, 10:57 p.m. CBG was noted to be 6.0 On 11/2/24, 2:51 a.m. CBG was noted to be 62. On 8/30/24, 6:38 a.m. CBG was noted to be 68. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident's eMAR and clinical progress notes indicated the resident was not assessed for hyperglycemia, the blood glucose was not monitored for effectiveness of treatment, failed to follow interventions of the care plan, and the physician was not notified of abnormal results on the above listed dates. Review of the care plan dated 9/27/24, included diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness, monitor/document/report to MD as needed for signs and symptoms of hypo-/hyperglycemia. Review of the clinical record revealed Resident R91 was admitted to the facility on [DATE], with diagnoses that included diabetes, dysphagia (difficulty swallowing), and Schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly). Review of the MDS dated [DATE], indicated the diagnoses remain current. Review of a physician order dated 2/13/24, indicated to inject Aspart insulin (fast acting insulin) as per sliding scale with blood sugar results between 70-140 insulin to be held. On 11/13/24 Insulin Aspart inject 4 units subcutaneously with meals for DM hold if blood sugar less than 120 or skipping meals. Review of the clinical record electronic Medication Administration Record (eMAR) and blood glucose summary(BGS) revealed that the resident's CBG's were inconsistent and documented as follows: On 11/9/24, at 11:13 a.m. CBG was noted to be 82 in BGS summary and 106 in eMAR. On 11/9/24, at 9:47 p.m. CBG was noted to be 74 in BGS summary and 174 in eMAR. On 11/10/24, at 8:17 a.m. CBG was noted to be 115 in BGS summary and 137 in eMAR. On 11/10/24, at 12:05 p.m. CBG was noted to be 115 in BGS summary and 143 in eMAR. On 11/11/24, at 11:01 a.m. CBG was noted to be 90 in BGS summary and 171 in eMAR. On 11/13/24 there is no documentation of a BGS in either the summary or eMAR or that insulin was given. Review of Resident's eMAR and clinical progress notes indicated the resident received insulin for documented blood sugar results and as per order with no interventions required. Review of the care plan dated 9/3/24, included diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness, monitor/document/report to MD as needed signs and symptoms of hypo-/hyperglycemia. (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 11/13/24, at approximately 8:50 a.m. Licensed Practical Nurse (LPN) Employee E5 stated for residents without diabetic parameters they would notify the doctor for blood glucose levels under 70, assess if unresponsive give Glucagon (medicine to increase blood sugar), if responsive give glucose gel, or over 400, give insulin per order, call doctor and document in progress notes. LPN Employee E5 stated that if order for insulin states to hold insulin for levels less than 120 would hold the insulin, document that it was not given and notify the physician. During an interview on 11/14/24, at 11:30 a.m. the Director of Nursing (DON) confirmed the facility failed to provide timely and complete communication to a physician when there was a change in condition. The DON confirmed the facility failed to recognize, assist and document the treatment of complications commonly associated with diabetes. Documentation should reflect the carefully assessed diabetic resident for vital signs, skin (color, temperature, dryness, sweating, irritation or abrasions), percentage of meals consumed, mood changes, pain, restlessness, numbness/tingling, results of any fingerstick, interventions to stabilize the blood glucose levels and response, notification of physician of unstable or significant variances from base line per physician order. The DON confirmed that documentation should be checked for accuracy in results so that no confusion will occur in the administration of medication. 28 Pa. Code: 201.18 (b)(1) Management. 28 Pa. Code: 201.29(d) Resident rights. 28 Pa. Code: 211.10 (c)(d) Resident care policies. 28 Pa. Code: 211.12 (d)(1)(2)(3)(5) Nursing services.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43725 Based on review of facility policy, manufacturers recommendations,resident interviews, clinical records, and staff interviews, it was determined that the facility failed to make certain medications were administered as ordered by the physician for two of five residents (Residents R52 and R69) and failed to make certain that residents are free of significant medication errors for two of three residents observed (Resident R301, and R24.) Findings include: A review of facility policy Medication Administration dated 8/21/23, and 4/18/24, indicated facility staff should comply with facility policy to provide guidance of general medication administration to be provided by personnel recognized as legally able to administer medications only as prescribed by the provider. Observe the five rights in giving medication: (i) the right resident, (ii) the right time, (iii) the right medicine, (iv) the right dose, (v) the right route. A review of the manufacturers guideline for glargine insulin (Lantus - long-acting type of insulin that works slowly, over about 24 hours) Solostar prefilled pen, November 2000, specified to perform a safety test before each injection. Select a dose of two units, hold the pen with the needle pointing upwards, gently tap the reservoir to remove air bubbles, press the injection button all the way in and check if insulin comes out of the needle tip. A review of the manufacturers guideline for a fast-acting insulin (Novolog/Humalog - starts to work about 15 minutes after injection, peaks in about 1 hour, and keeps working for two to four hours) Flextouch prefilled pen indicated priming the pen by turning the dose selector to select two units, hold the pen with the tip facing upwards, gently tap the top of the reservoir to remove air bubbles, press the dose button until the dose counter returns to zero, a drop of insulin should be seen at the needle tip. A review of the clinical record indicated that Resident R52 was admitted to the facility on [DATE], with diagnoses that included diabetes, bilateral below knee amputations, chronic kidney disease (The kidneys filter waste and excess fluid from the blood, as the kidneys fail they no longer filter waste). A review of a physician order dated 10/4/24, indicated to check blood sugar (BS) before meals and give Lispro flex pen (short-acting insulin) inject 3 units subcutaneously with meals, hold if blood sugar is less than 120. A review of the medication administration record (MAR) dated November 2024 indicated that Resident R52 received insulin on 11/1/24, 11/12/24, and 11/13/24 against order to hold if blood sugar is less than 120. A review of the clinical record, blood glucose summary, showed that on 11/1/24 at 8:01 a.m., BS was 81, 11/12/24 at 7:56 a.m , BS was 90, and on 11/13/24 at 7:36 a.m , BS was 92. (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	11/15/2024

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the clinical record indicated that Resident R69 was admitted to the facility on [DATE], with diagnoses that included diabetes, obesity, dementia (a group of thinking and social symptoms that interferes with daily functioning). A review of a physician order dated 8/19/22, indicated to check BS early AM every day. On 10/26/23 an order for Novolog insulin (short-acting insulin) to be given per sliding scale, if BS result less than 130 to hold. A review of the MAR dated November 2024, indicated that Resident R69 did not have a documented result on 11/13/24, or that insulin was given as ordered. A review of the clinical record indicated that Resident R69 blood sugar summary showed a result on 11/13/24, at 8:20 a.m to be 80, which was not carried over to the eMAR and no documentation was made to hold the insulin. During an interview on 11/14/24 at 11:30 a.m., the Director of Nursing confirmed the above findings and that the facility failed to make certain medications were administered as ordered by the physician for Residents R52 and R69. A review of a clinical record indicated Resident R301 was admitted to the facility on [DATE], with diagnoses that included diabetes, repeated falls, and muscle weakness. A review of a physician orders dated 11/6/24, indicated to inject insulin Lispro (fast-acting) per sliding scale. If blood glucose was between 141 - 180, give two units of insulin. Further review of a physician order dated 11/6/24, indicated to inject insulin glargine 18 units one time a day. During an observation on 11/13/24, at 8:42 a.m. of Resident R301's medication administration Licensed Practical Nurse (LPN) Employee E4 indicated Resident R301's blood sugar was 158. LPN Employee E4 set the Lispro insulin pen to two units and set the glargine insulin pen to 18 units, failed to prime either insulin pen and administered the medications. A review of a clinical record indicated Resident R24 was readmitted to the facility on [DATE], with diagnoses that included diabetes, high blood pressure, and obesity. A review of a physician order dated 9/2/24, indicated to inject insulin Aspart (short-acting) per sliding scale before meals. If blood glucose was between 181 - 220, give four units of insulin. During an observation on 11/13/24, at 12:18 p.m. of Resident R24's medication administration LPN Employee E3 indicated Resident R24 ' s blood sugar was 182, set the insulin pen to four units of insulin, failed to prime the pen, and administered the medication. During an interview on 11/13/24, at 12:40 p.m. LPN Employee E3 confirmed she failed to prime the insulin pen prior to administering the medication. During an interview on 11/13/24, at 1:15 p.m. the Director of Nursing confirmed that facility failed to administer the correct dose of insulin by failing to prime the insulin pen needle for Residents R301, and R24. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28 Pa. Code 211.12 (c)(1)(3) Nursing Services. 28 Pa. Code 201.29 (j) Resident rights. 28 Pa Code: 201.18 (b)(1)(3) Management. 28 Pa Code: 211.10 (d) Resident care policies.

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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. 43725 Based on review of facility policy, observations and staff interviews, it was determined that the facility failed to maintain infection control practices to prevent the potential for cross contamination during a dressing change. Findings include: Review of the facility policy Skin Care & Wound Management Overview reviewed 4/18/24, indicated each resident is evaluated upon admission and weekly thereafter for changes in skin condition. Application of treatment protocols based on clinical best practice standards for promoting wound healing. Review of the facility policy Infection Control Program reviewed 4/18/24, indicated residents have a right to reside in a safe environment that promotes health and reduces the risk of acquiring infections. Policies, procedures, and aseptic practices are followed by employees in performing procedures and in disinfection of equipment. During an observation on 9/19/24, at 1:30 p.m. with Licensed Practical Nurse (LPN) Employee E1 the following occurred during a dressing change: -supplies gathered, scissors removed from treatment cart, scissors were not cleansed -table cleansed with wipe, allowed to dry, and towel placed as barrier, supplies placed on barrier -ABHS (alcohol-based hand sanitizer) used, gloves donned -scissors used to cut tape to size, initials/date wrote on tape , scissors again ot cleansed prior to use -soiled gloves removed, ABHS used, clean gloved donned LEFT LEG wounds: -soiled dressing removed with scissors, these were again not cleansed prior to use. -drape placed under leg -soiled gloves removed, ABHS used, clean gloves donned -wounds cleansed with wound cleanser spray, dried with gauze 4x4's -Vaseline dressing opened and cut to size with scissors that remained uncleaned -dressing placed on wounds -ABD pad placed over wound, wrapped with cling gauze (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-gauze cut with scissors, same scissors, not cleansed -cling gauze secured with dated/initialed tape -gloves removed, ABHS used, clean gloves donned RIGHT LEG wounds: -scissors used to removed soiled dressing, same scissors used, remained not cleansed -towel placed under right leg -cleansed with wound cleanser spray, dried with gauze 4x4 -soiled gloves removed, ABHS used, clean gloves donned -scissors used to cut Vaseline dressing to wound sizes, same scissors remained not cleansed -ABD pad cut in half with scissors and placed over dressings. scissors continue to remain uncleaned -wrapped with cling gauze, gauze cut to shorten with the continued use of uncleaned scissors -tape placed to secure SACRAL wound: -soiled gloves removed, ABHS used, clean gloves donned -cleansed with wound spray and dried with gauze 4x4's -hydrophilic wound dressing cream placed on gloved hand and wiped onto buttocks -soiled gloves removed, ABHS used, clean gloves donned -zinc oxide ointment placed on ABD pad and placed on buttocks -soiled supplies gathered in bag and placed in soiled utility -hands washed with soap. During an interview on 11/14/24, at 2:15 p.m. LPN Employee E1 confirmed she failed to cleanse the scissors in between soiled and clean items. During an interview on 11/14/24, at 2:25 p.m. the Director of Nursing confirmed the facility failed to prevent cross contamination during a dressing change, 28 Pa. Code: 201.20(c) Staff development. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa. Code: 201.14(a) Responsibility of licensee. 28 Pa. Code: 201.18(b)(1)(e)(1) Management. 28 Pa. Code: 211.10(d) Resident care policies. 28 Pa. Code: 211.12(d)(1)(2)(3)(5) Nursing services.