STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395041	A. Building B. Wing	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Twinbrook Healthcare and Rehabilitation Center	3805 Field Street Erie, PA 16511

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48496 Based on review of facility policy and clinical records, observations, and staff interview, it was determined that the facility failed to provide resident privacy and dignity regarding an exposed urinary catheter (a tube placed and held in the bladder to drain urine) bag for two of two residents reviewed for catheters (Residents R8 and R69). Findings include: Review of facility policy entitled, Indwelling Catheter Use and Storage dated 4/26/24, indicated Additional care practices include .keeping the catheter bag covered for resident's dignity and privacy. Review of Resident R8's clinical record revealed an admitted [DATE], with diagnoses that included neuromuscular dysfunction of bladder (a condition when a person lacks bladder control due to the muscles and nerves that control the bladder not working properly), diabetes, and heart failure (a condition where the heart cannot supply the body with enough blood). Observation on 5/14/24, at 1:03 p.m. revealed Resident R8 was in his/her room laying in his/her bed with his/her urinary catheter drainage bag hanging on his/her bed frame. The urinary catheter drainage bag was visible from the hallway and lacked a privacy cover. Further observation on 5/14/24, at 3:15 p.m. revealed Resident R8's urinary catheter drainage bag continued to be hanging from his/her bed frame, visible from the hallway and lacking a privacy cover. Review of Resident R69's clinical record revealed an admitted [DATE], with diagnoses that included diabetes, orthostatic hypotension (a condition when your blood pressure drops suddenly when you stand up making you feel dizzy or faint), and venous thrombosis (a blood clot that blocks the flow of blood). Observation on 5/14/24, at 1:03 p.m. revealed Resident R69 was in his/her room laying in his/her bed with his/her urinary catheter drainage bag hanging on his/her bed frame. The urinary catheter drainage bag was visible from the hallway and lacked a privacy cover. Further observation on 5/14/24, at 3:15 p.m. revealed Resident R69's urinary catheter drainage bag continued to be hanging from his/her bed frame, visible from the hallway and lacking a privacy cover. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/14/24, at 3:22 p.m. the Director of Nursing (DON), confirmed that Resident R8 and Resident R69's catheter drainage bags lacked privacy covers. He/she also confirmed that all catheter drainage bags should be covered to ensure resident privacy and dignity. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 211.12(d)(1)(5) Nursing Services

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47356 Based on review of facility policy and clinical record, and staff interview, it was determined that the facility failed to provide a written summary of the baseline care plan and order summary to the resident and/or representative for one of 20 residents reviewed (Resident R60). Findings include: A facility policy entitled, Baseline Care Plan dated 4/26/24, revealed A written summary of the baseline care plan shall be provided to the resident and representative in a language that the resident/representative can understand. The summary shall include at a minimum the following: a. The initial goals of the resident. b. A summary of the resident's medications and dietary instructions. c. Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. Resident R60's clinical record revealed an admitted [DATE], with diagnoses that included chronic respiratory failure, pneumonia (an infection in the lungs), and epileptic seizures (a sudden uncontrolled electric disturbance in the brain that can cause changes in behaviors and movements). R60's clinical record lacked evidence that a written summary of the baseline care plan and order summary was provided to Resident R60 and/or his/her representative. During an interview on 5/16/24, at 2:20 p.m. the Director of Nursing confirmed that the clinical record for Resident R60 lacked evidence that a written summary of the baseline care plan and order summary was provided to the resident and/or his/her representative upon admission to the facility. 28 Pa. Code 211.12(d)(1)(5) Nursing services

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40832 Based on review of facility policy and clinical records, and staff interview, it was determined that the facility failed to develop and implement resident centered comprehensive care plans for four of 20 residents reviewed (Residents R19, R51, R54, and R66). Findings: A facility policy entitled Oxygen Administration dated 4/26/24, indicated the resident's care plan shall identify the interventions for oxygen therapy, based upon the resident's assessment and orders, such as, but not limited to a. type of oxygen delivery system; b. when to administer, such as continuous or intermittent and/or when to discontinue; c. equipment setting for the prescribed flow rates; d. monitoring of SpO2 (oxygen saturation) levels and/or vital signs, as ordered; and e. monitoring for complications associated with the use of oxygen. Resident R19's clinical record revealed an admitted [DATE], with diagnoses that included heart disease, irregular heartbeat, heart failure, and obstructive sleep apnea (condition that occurs when the throat muscles relax and block the airway). A physician's order dated 1/10/24, revealed to administer supplemental oxygen (O2) at two liters per minute (lpm) via nasal cannula (n.c.- a flexible oxygen delivery tubing that consists of two prongs protruding from the center of a disposable tube to insert into the nostrils) to maintain saturations greater than 90% as needed every shift. Further review of Resident R19's clinical record lacked evidence of a comprehensive care plan to guide staff on providing resident centered care regarding the use of supplemental oxygen. Resident R51's clinical record revealed an admitted [DATE], with diagnoses that included long-term respiratory failure, high blood pressure, bipolar disorder (mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration), anxiety, and adjustment disorder. A physician's order dated 1/10/24, revealed to administer O2 at three lpm via n.c., maintain saturations above 89%, titrate (adjust) to discontinue oxygen as needed for saturations less than 89% for shortness of breath/anxiety. Further review of Resident R51's clinical record revealed comprehensive care plans entitled: 1) respiratory impairment dated 1/31/22, and included an intervention to administer O2 at three liters via n.c.; 2) oxygen therapy dated 2/28/22, and included interventions to monitor for signs of respiratory distress and to promote lung expansion and improve air exchange by positioning with proper body alignment. The Resident R51's comprehensive care plans lacked evidence of interventions to guide staff on providing resident centered care regarding the use of supplemental oxygen. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident R54's clinical record revealed an admitted [DATE], with diagnoses that included heart disease, respiratory failure, chronic obstructive pulmonary disease (COPD- chronic inflammatory lung disease that causes obstructed airflow from the lungs), high blood pressure, and bipolar disorder. A physician's order dated 5/10/24, revealed to administer O2 at three lpm, titrate down to maintain saturations above 90%, humidify oxygen via n.c. every shift. Further review of Resident R54's clinical record revealed a comprehensive care plans entitled: 1) cardiac disease dated 11/25/22, and included an intervention to administer O2 at two lpm via nc; 2) risk for infection dated 2/27/24, included the intervention to screen daily for elevated temperature, respiratory rate, and O2 saturation; and 3) risk for respiratory impairment dated 12/20/23, included an intervention to administer O2 at one-two via n.c. The Resident R54's comprehensive care plans lacked evidence of interventions to guide staff on providing resident centered care regarding the use of supplemental oxygen. Resident R66's clinical record revealed an admitted [DATE], with diagnoses including COPD, end-stage renal disease, aorta bypass graft (procedure done to treat a blockage or narrowing of 1 or more of the coronary arteries), and heart failure. A physician's order dated 3/22/24, revealed to administer oxygen at two liters/minute via n.c. as needed for shortness of breath. Further review of Resident R66's clinical record revealed a comprehensive care plan entitled risk for respiratory impairment dated 2/10/24, and included the intervention for oxygen at two liters via n.c. Resident R66's comprehensive care plan lacked evidence of interventions to guide staff on providing resident centered care regarding the use of supplemental oxygen. During an interview on 5/16/24, at 10:40 a.m. the Assistant Director of Nursing confirmed that the comprehensive care plans for Residents R19, R51, R54, and R66 lacked adequate interventions to guide staff on providing resident centered care for the use of supplemental oxygen. 28 Pa. Code 211.12(d)(1)(5) Nursing services

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48496 Based on review of facility policy and clinical records, and staff interview, it was determined that the facility failed to review and revise comprehensive care plans to reflect the current care and services for three of 20 residents reviewed (Residents R4, R20, and R58). Findings include: Review of facility policy entitled Care Plan Revision Upon Status Change dated 4/26/24, indicated that The comprehensive care plan will be reviewed, and revised as necessary, when a resident experiences a status change. Resident R4's clinical record revealed an admitted [DATE], with diagnoses that included obstructive sleep apnea (a sleeping disorder where a person's breathing repeatedly stops and starts while sleeping), hypertension (high blood pressure), diabetes, and hyperlipidemia (high cholesterol). Review of care plan meeting documentation for Resident R4 revealed a care plan meeting was completed on 3/14/24. Review of Resident R4's clinical record revealed a physician order dated 12/5/23, for continuous positive airway pressure (CPAP), must wear every night. Review of Resident R4's care plans lacked evidence of a care plan to address the CPAP. Resident R20's clinical record revealed an admitted [DATE], with diagnoses that included diabetes, hypertension, and chronic kidney disease (a disease that affects the kidney's ability to filter waste products and extra fluid from the body). Review of care plan meeting documentation for Resident R20 revealed a care plan meeting was completed on 4/9/24. Review of Resident R20's care plans revealed a care plan to address pain with a target date (a date that the care plan is to be updated by) of 4/9/24. Resident R58's clinical record revealed an admitted [DATE], with diagnoses that included chronic obstructive pulmonary disease (when your lungs do not have adequate air flow), hypertension, and anxiety (a condition that causes a person to be nervous, uneasy, or worried about something or someone). Review of care plan meeting documentation for Resident R58 revealed a care plan meeting was completed on 3/14/24. Review of Resident R58's physician orders revealed an order for oxygen at four liters per minute dated 1/5/24. Review of Resident R58's care plans to address respiratory care revealed under interventions for oxygen at two liters per minute with a revision date of 3/28/24. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/16/24, at 1:25 p.m. the Director of Nursing confirmed the care plans for Residents R4, R20 and R58 were not reviewed/revised to reflect current resident care and services. He/she also confirmed that care plans should be reviewed and revised as required. 28 Pa. Code 211.10(c)(d) Resident care policies 28 Pa. Code 211.12(d)(1)(5) Nursing services

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40832 Based on review of facility policy and clinical records, observations, and staff interview, it was determined that the facility failed to promote cleanliness and prevent the potential spread of infection regarding respiratory care equipment according to physician's orders for six of 20 residents (Residents R4, R19, R51, R54, R58, and R66). Findings: A facility policy entitled Oxygen Administration dated 4/26/24, indicated: oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goals and preferences; infection control measures included, a. clean/rinse oxygen concentrator (take air from your surroundings, extract oxygen and filter it into purified oxygen for you to breathe) filter weekly, change as needed; b. change oxygen tubing (lightweight tube used to delivery supplemental oxygen) and mask/cannula weekly and as needed if it becomes soiled of contaminated; c. clean humidifier bottle when empty, change weekly, use only sterile water for humidification; d. keep delivery devices covered in plastic bags when not in use. Resident R19's clinical record revealed an admitted [DATE], with diagnoses that included heart disease, irregular heartbeat, heart failure, and obstructive sleep apnea (occurs when the throat muscles relax and block the airway). A physician's order dated 12/05/23, revealed to change oxygen tubing and canister, and clean oxygen concentrator filter on night shift every Tuesday. Observation on 5/14/24, at 1:18 p.m. revealed Resident R19's oxygen tubing was dated 4/24/24, and hanging over the handle of his/her bedside stand, the humidifier bottle was dated 5/01/24. The humidifier tubing was not attached to the concentrator, the water canister was almost empty, and the concentrator filters were covered with a white, fluffy substance. During an interview at that time, Resident R19 stated not sure how long the humidifier tubing had been disconnected. Additional observation on 5/14/24, at 3:15 p.m. (during medication administration), revealed that Resident R19 reported to medication nurse that the surveyor was 'looking' at the humidifier bottle earlier, and the medication nurse reconnected the humidifier bottle tubing to the concentrator. Resident R51's clinical record revealed an admitted [DATE], with diagnoses that included long-term respiratory failure, high blood pressure, bipolar disorder (mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration), anxiety (a condition that causes a person to be nervous, uneasy, or worried about something or someone), and adjustment disorder. A physician's order dated 12/05/23, revealed to change oxygen tubing and canister, and clean oxygen concentrator filter on night shift every Tuesday. Observation on 5/14/24, at 1:39 p.m. revealed Resident R51's oxygen tubing was dated 4/24/24, and the concentrator filters were covered with a white, fluffy substance. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident R54's clinical record revealed an admitted [DATE], with diagnoses that included heart disease, respiratory failure, chronic obstructive pulmonary disease (COPD- chronic inflammatory lung disease that causes obstructed airflow from the lungs), high blood pressure, and bipolar disorder. A physician's order dated 12/21/23, revealed to change oxygen tubing and canister, and clean oxygen concentrator filter on night shift every Tuesday. Observation on 5/14/24, at 1:34 p.m. revealed Resident R54's oxygen tubing was dated 4/24/24, and the concentrator filters were covered with a white, fluffy substance. Resident R66's clinical record revealed an admitted [DATE], with diagnoses that included COPD, end-stage renal disease, aorta bypass graft (procedure done to treat a blockage or narrowing of one or more of the coronary arteries), and heart failure. A physician's order dated 3/22/24, revealed to change oxygen tubing and canister, and clean oxygen concentrator filter on night shift every Tuesday. Observation on 5/14/24, at 1:45 p.m. revealed Resident R66's oxygen tubing was dated 5/01/24, and the concentrator filters were covered with a white, fluffy substance. Resident R4's clinical record revealed an admitted [DATE], with diagnosis that included obstructive sleep apnea (a sleeping disorder where a person's breathing repeatedly stops and starts while sleeping), Hypertension (high blood pressure), diabetes, and hyperlipidemia (high cholesterol). Review of Resident R4's physician orders revealed an order that Resident R4 Must wear continuous positive airway pressure (CPAP) every night. Observation on 5/14/24, at 1:35 p.m. revealed Resident R4's CPAP machine (a machine that prevents breathing interruptions caused by sleep apnea) with the tubing and face mask attached to the machine. The face mask was laying on the floor with no barrier between the face mask and the floor. Further observation on 5/14/24, at 3:40 p.m. revealed Resident R4's CPAP mask continued to lay on the floor without a barrier between the mask and floor. Resident R58's clinical record revealed an admitted [DATE], with diagnoses that included COPD, hypertension, and anxiety. Observation on 5/14/24, at 1:30 p.m. revealed oxygen tubing was dated 5/1/24, humification bottle was dated 4/24/24, and filters to bilateral sides of the oxygen concentrator were covered with a white, fluffy substance. During an interview on 5/14/24, at 3:43 p.m. the Director of Nursing confirmed the dates on Residents R19, R51, R54, R58, and R66's oxygen tubing, humidifier bottles, and that the concentrator filters were dirty and Resident R4's CPAP mask was laying on the floor with no barrier between the mask and floor. He/she also confirmed that oxygen tubing, humidifier bottles and concentrator filters should be changed/cleaned per physician orders and the CPAP mask should have not been laying on the floor. 28 Pa. Code 211.12(d)(1)(5) Nursing services

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40832 Based on review of manufacturer's recommendations, facility policy, and clinical records, and staff interviews it was determined that the facility failed to ensure that pain management was provided to residents who require such services, consistent with professional standards of practice for one of 20 residents reviewed (Resident R19). Findings include: Review of manufacturer's recommendations for administering acetaminophen (Tylenol) included not to exceed six tablets in 24 hours. A facility policy entitled Medication Administration dated 4/26/24, indicated that medications will be administered as ordered and in accordance with manufacturer's specifications. Resident R19's clinical record revealed an admitted [DATE], with diagnoses that included heart disease, irregular heartbeat, heart failure, and obstructive sleep apnea (condition that occurs when the throat muscles relax and block the airway). A physician's order dated 4/12/24, instructed staff to administer two acetaminophen 500 milligram (mg) tablets every four hours as needed for pain to Resident R19 (or up to 12 tablets 24 hours). Resident R19's clinical record revealed that he/she was administered acetaminophen 1,000 mg on 4/24/24, at 4:54 p.m. and 5:03 p.m., and on 4/25/24, at 4:46 p.m. and 5:22 p.m. During an interview on 5/16/24, at 1:50 p.m. the Director of Nursing confirmed that the physician's order for two acetaminophen 500 mg tablets every four hours exceeded the manufacturer's recommendations and staff incorrectly administered 1,000 mg of acetaminophen on 4/24/24, at 4:54 p.m. and 5:03 p.m., and on 4/25/24, at 4:46 p.m. and 5:22 p.m. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47356 Based on a review of facility policy and clinical records, and staff interview, it was determined that the facility failed to implement procedures to promote accurate and safe disposition of controlled medication records for one of three closed records reviewed (Resident CR94). Findings include: Review of the facility policy, entitled Disposal of Medications, dated 4/26/24, indicated, Controlled Substances listed in Schedules II, III, IV, and V remaining in the nursing care center after the order has been discontinued are retained in the nursing care center in a securely double locked area with restricted access until destroyed as outlined by state regulation. For the State of Pennsylvania, these controlled substances shall be disposed of by the nursing care center in the presence of appropriately titled professionals two licensed nurses employed by the nursing center. A controlled medication disposition log, or equivalent form shall be used for documentation and shall be retained as per federal privacy and state regulations. This log shall contain the following information, Resident's name, Medication name and strength, Prescription number, Quantity/amount disposed, Date of disposition, and Signatures of the required witnesses. Review of Resident CR94's closed clinical record revealed admission to the facility on [DATE]. Resident CR94 ceased to breathe on 2/23/24. Review of Resident CR94's closed clinical record revealed a lack of evidence that two licensed nurses were present and signed on 1/24/24, and 2/12/24, for the removal of and destruction of Resident CR94's Fentanyl 25 micrograms/hour (mcg/hr) patch (a controlled schedule II drug used for pain management) and lacked evidence of the destruction of or return to pharmacy for Resident CR94's 22 remaining does of Methadone HCL 10 (milligram) mg Tablets (a controlled schedule II drug used for pain management). During an interview on 5/16/24, at 3:00 p.m. the Director of Nursing confirmed that Resident CR94's disposition of medications documentation lacked evidence that two licensed nurses were present and signed on 1/24/24, and 2/12/24, for the removal of and destruction of Resident CR94's Fentanyl 25 mcg/hr patch and lacked evidence of the destruction of or return to pharmacy for Resident CR94's 22 remaining does of Methadone HCL 10 mg tablets. 28 Pa. Code 211.9(a) Pharmacy services 28 Pa. Code 211.12(d)(3) Nursing services

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40832 Based on review of facility policy and clinical records, and staff interview, it was determined that the facility failed to ensure that a pharmacist's recommendation was reviewed and acted upon for one of 20 residents reviewed (Resident R19). Findings: A facility policy entitled Medication Regimen Review dated 4/26/24, indicated that facility staff shall act upon all recommendations according to procedures for addressing medication regimen review irregularities. Resident R19's clinical record revealed an admitted [DATE], with diagnoses that included heart disease, irregular heartbeat, heart failure, and obstructive sleep apnea (occurs when the throat muscles relax and block the airway). Resident R19's departmental progress notes revealed that on 1/27/24, the consultant pharmacist identified irregularities with Resident R19's medication regimen and referred to see the report. Resident R19's clinical record lacked evidence of a pharmacy recommendation report for January 2024 addressing the irregularities. During an interview on 5/16/24, at 2:00 p.m. the Director of Nursing confirmed there was no evidence that Resident R19's clinical record contained a pharmacy recommendation report for the irregularities identified 1/27/24. 28 Pa. Code 211.5(f)(x) Medical records 28 Pa. Code 211.10 (c) Resident care policies 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services