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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395500 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 07/03/2024 |
| NAME OF PROVIDER OR SUPPLIER Twin Lakes Rehabilitation and Healthcare Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 227 Sand Hill Road Greensburg, PA 15601 | |

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) |
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| <p>F 0553</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Allow resident to participate in the development and implementation of his or her person-centered plan of care.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43856</p> <p>Based on review of policies and clinical records, as well as staff and family interviews, it was determined that the facility failed to routinely conduct care plan meetings and invite the resident or representative to attend for one of six residents reviewed (Resident 6).</p> <p>Findings include:</p> <p>The facility's policy regarding assessment/care plans, dated January 10, 2024, revealed that the resident and his or her representative are encouraged to participate in the resident's assessment and in the development and implementation of the resident's care plan. The resident/representative's right to participate in the development and implementation of his or her plan of care includes the right to participate in the planning process, request meetings, and request revisions to the plan of care.</p> <p>A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 6, dated June 11, 2024, indicated that the resident was confused, required extensive assistance with activities of daily living, and had diagnoses that included dementia, anxiety and mood disturbance. Resident 6 was admitted to the facility on [DATE].</p> <p>Interview with resident's daughter on July 3, 2024, at 12:37 p.m. revealed that Resident 6 refuses care frequently and has skin care needs to her right lower leg. She also revealed that there has not been a meeting with the resident or family to discuss the continued refusals of care and a change in the plan of care to address the refusals.</p> <p>A review of Resident 6's medical record revealed that there was no documented evidence of a meeting with the resident and her representative to participate in the plan of care since admission on April 7, 2022.</p> <p>Interview with the Nursing Home Administrator on July 3, 2024, at 2:00 p.m. confirmed that there was not a care planning meeting with the resident or her representative to participate in her plan of care since her admission on April 7, 2022 and there should have been.</p> <p>28 Pa. Code 201.24(e)(4) Admission Policy.</p> <p>28 Pa. Code 201.18(e)(1) Management.</p> |

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

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>43856</p> <p>Based on review of clinical records and facility assessment reports, as well as staff interviews, it was determined that the facility failed to complete safety assessments for one of six residents reviewed (Resident 4) who used an air mattress.</p> <p>Findings include:</p> <p>A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 4, dated May 15, 2024, revealed that the resident was cognitively impaired, was totally dependent on facility staff with care needs, had multiple pressure ulcers, had a feeding tube, and was at risk for falls. A care plan for Resident 4, dated January 15, 2024, indicated that the resident was at risk for falls related to impaired mobility.</p> <p>Physician's orders for Resident 4, dated January 17, 2024, indicated that she was to have an air mattress with bolsters.</p> <p>A nursing note for Resident 4, dated March 30, 2024, at 4:15 a.m., revealed that the resident was found on the floor lying on her right side. An air mattress assessment was completed on June 6, 2024.</p> <p>A nursing note for Resident 4, dated June 7, 2024, at 5:44 p.m., revealed that the resident was found on the floor between her bed and the window. Her mattress was fully inflated and she was wearing no-slip socks. It was noted that she had partially digested stomach contents all over her and on the floor, presumably from the dislodged gastric tube (a tube insert into the abdomen into the stomach to provide nutrition). Resident 4 had a large bump on her head as well as a small 2 centimeter (cm) laceration.</p> <p>Observations of Resident 4 on July 3, 2024, at 9:51 a.m. revealed that she was on an air mattress with bolsters, with fall mats. Her legs were bent at the knees in a contracture, her right arm was bent at the elbow, and her right fingers were in a contracture.</p> <p>There was no documented evidence that the continued use of Resident 4's air mattress was assessed for potential safety hazards following the unwitnessed fall from bed on June 7, 2024.</p> <p>Interview with the Director of Nursing on July 3, 2024, at 2:27 and 2:38 p.m. confirmed that an air mattress safety assessment was not completed following the fall on June 7, 2024, because she had one completed on June 6, 2024, and there had been no changes.</p> <p>28 Pa. Code 201.14(a) Responsibility of Licensee.</p> <p>28 Pa. Code 201.18(b)(1)(e)(1) Management.</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.</p> | | |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide and implement an infection prevention and control program.</p> <p>43856</p> <p>Based on review of established infection control guidelines and residents' clinical records, as well as observations and staff interviews, it was determined that the facility failed to follow infection control guidelines from the Centers for Medicare/Medicaid Services (CMS) and the Centers for Disease Control (CDC) to reduce the spread of infections and prevent cross-contamination for two of six residents reviewed (Residents 1, 4).</p> <p>Findings include:</p> <p>CDC guidance on isolation precautions and Implementation of Personal Protective Equipment (PPE) use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), dated July 12, 2022, indicates that multidrug-resistant organism (MDRO) transmission is common in skilled nursing facilities, contributing to substantial resident morbidity and mortality and increased healthcare costs. Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities. CMS updated its infection prevention and control guidance effective April 1, 2024. The recommendations now include the use of EBP during high-contact care activities for residents with chronic wounds or indwelling medical devices, regardless of their MDRO status, in addition to residents who have an infection or colonization with a CDC-targeted or other epidemiologically important MDRO when contact precautions do not apply.</p> <p>The facility's policy regarding Enhanced Barrier Precautions, dated January 10, 2024, indicated that gloves and a gown are used during high contact resident care, which includes bathing and showering.</p> <p>A admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 1, dated June 26, 2024, revealed that the resident was clearly understood and could understand others, required assistance with care needs, and had a catheter (a thin, flexible tube inserted into the bladder to drain urine from the bladder). A care plan for Resident 1 regarding enhanced barrier precautions, dated June 20, 2024, revealed that the resident had EPB in place due to foley catheter placement.</p> <p>Physician's orders for Resident 1, dated May 1, 2024, included an order for resident to receive enhanced barrier precautions due to foley catheter placement every shift.</p> <p>Observations of Resident 1 on July 2, 2024, at 9:49 a.m. revealed that the resident had signage at the entrance to his room to indicate that infection control measures for EBP were in place related to his catheter. Nurse Aide 1 and Nurse Aide 2 were wearing gloves while providing a bed bath to Resident 1.</p> <p>Interview with Nurse Aide 1 and Nurse Aide 2 on July 2, 2024, at 10:25 a.m. revealed that they were not aware that a gown was required during a bed bath.</p> <p>Interview with the Infection Prevention Nurse on July 3, 2024, at 10:34 a.m. confirmed that Resident 1 had EBP, and staff should have been wearing a gown and gloves while providing a bed bath.</p> <p>(continued on next page)</p> | | |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>A quarterly MDS assessment for Resident 4, dated May 15, 2024, revealed that the resident was cognitively impaired, was totally dependent on facility staff with care needs, had multiple pressure ulcers, and had a feeding tube. A care plan for Resident 4, dated January 15, 2024, indicated that the resident was at risk for infection related to history of clostridioides difficile (c-diff infection in colon causing diarrhea), a peg tube, and wounds with an intervention of enhanced barrier precautions.</p> <p>Observations of Resident 4 on July 3, 2024, at 9:51 a.m. revealed that she was on her bed receiving a bed bath provided by Nurse Aide 3 and Nurse Aide 4. Both nurse aides were only wearing gloves while providing care. There was an umbrella picture (facility's picture notification of precautions) on the wall behind the bed and gowns for staff use. Interview with the Nurse Aides 3 and 4 at 9:55 a.m. indicated that they forgot, did not see the the gowns available at bed side, and should have been wearing a gown while providing care to the resident.</p> <p>Interview with the Infection Prevention Nurse on July 3, 2024, at 1:18 p.m. confirmed that Resident 4 had EBP, and staff should have been wearing a gown and gloves while providing a bed bath.</p> <p>28 Pa. Code 201.14(a) Responsibility of Licensee.</p> <p>28 Pa. Code 201.18(e)(1) Management.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing Services.</p> |