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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 09/11/2024 |
| 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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>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.</p> <p>41233</p> <p>Based on observations and staff interviews, it was determined that the facility failed to provide a clean, homelike environment for one of 15 residents reviewed (Resident 10).</p> <p>Findings include:</p> <p>The facility's policy titled Homelike Environment, dated July 26, 2024, revealed that the objective was to provide a safe, clean, comfortable and homelike environment for residents.</p> <p>A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 10, dated September 1, 2024, revealed that the resident was cognitively intact, required assistance with most daily care needs, and had diagnoses that included COPD (congestive obstructive pulmonary disease), quadriplegia, and drug abuse.</p> <p>Observations on September 11, 2024, at 9:39 a.m. of Resident 10 in his room sitting in his electric wheelchair revealed an accumulation of dust, dirt and debris on the resident's bed, floor, and in the bathroom. There were three dried-up alcohol wipes, straws, and straw papers scattered about, as well as crumbs and a large amount of generalized dirt and debris throughout the room. The bathroom had bits of paper and dirt on the floor, the garbage can was overflowing with paper towels, and the toilet was dirty with dried pieces of a brown substance.</p> <p>Interview with Housekeeper 1 and the Director of Housekeeping on September 11, 2024, at 9:57 a.m. confirmed that Resident 10's room and bathroom had a large accumulation of dirt, crumbs, and generalized debris and should not have. They went on to say that four staff members have left since August, and it has become difficult to keep the facility as clean as they would like it.</p> <p>Interview with the Nursing Home Administrator on September 11, 2024, at 3:51 p.m. confirmed that Resident 10's room and bathroom were not clean and should have been</p> <p>28 Pa. Code 201.29(j) Resident Rights.</p> <p>28 Pa. Code 207.2(a) Administrator's Responsibility.</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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>41233</p> <p>Based on review of clinical records and staff interviews, it was determined that the facility failed to ensure that treatments for pressure ulcers were provided as ordered by the physician for one of 15 residents reviewed (Resident 10).</p> <p>Findings include:</p> <p>The facility's policy regarding dressing and wound documentation, dated July 26, 2024, indicated that wound care/dressings and refusals should be documented on the resident's medical record, treatment sheet, or designated wound form.</p> <p>A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 10, dated September 1, 2024, revealed that the resident was cognitively intact, required assistance with daily care needs, and had diagnoses that included quadriplegia, drug abuse, and a pressure ulcer (injuries to skin and underlying tissue resulting from prolonged pressure).</p> <p>Current physician's orders for Resident 10, included an order for the resident's right ischium (pelvis), right iliac crest (hip bone), and right medial buttocks to be cleansed with Dakin's (antiseptic solution), then loosely packed with Dakin's wet to moist gauze and covered with abdominal pads. In addition, any areas of dermatitis (irritation of the skin) around the wounds were to be covered with ketoconazole (antifungal cream) daily and as needed.</p> <p>Review of Resident 10's Treatment Administration Record (TAR), dated August 2024, revealed no documented evidence that the resident's dressings to his right pelvis and hip pressure ulcer were completed or refused on August 16 and 20, 2024.</p> <p>Interview with the Director of Nursing on September 11, 2024, at 1:00 p.m. revealed that there was no documented evidence that Resident 10's pressure ulcer treatments were completed or refused on the above-mentioned dates and times, and there should have been.</p> <p>28 Pa. Code 211.12(d)(1)(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>31760</p> <p>Based on review of policies and clinical records, as well as observations and staff interviews, it was determined that the facility failed to ensure that proper infection control practices were performed during care for one of 15 residents reviewed (Resident 15).</p> <p>Findings include:</p> <p>The facility's policy regarding perineal care, dated July 26, 2024, indicated that staff was to discard disposable items into designated containers, remove gloves and discard into designated container, wash and dry hands thoroughly, reposition the bed covers, and make the resident comfortable.</p> <p>Observations during wound care on September 11, 2024, at 9:53 a.m. revealed that Wound Care Nurse 2 completed the physician's ordered treatment to the resident's coccyx (tailbone area) wound. The brief that was under the resident was heavily soiled with serosanguineous (blood and serum, the liquid part of blood) drainage. Wound Care Nurse 2 rolled up the soiled brief, placed a clean brief, then rolled Resident 15 onto his left side and removed the soiled brief, which then fell from the bed to the floor. Wound Care Nurse 2 straightened out the clean brief and rolled the resident back onto his back. She then picked up the soiled brief from the floor and placed the soiled brief into a garbage can. With the same gloves on and without washing her hands, she lifted the resident's legs and adjusted the pillow that was under his legs. She then placed the sheet and blanket over the resident.</p> <p>Interview with Wound Care Nurse 2 on September 11, 2024, at 10:09 a.m. confirmed that Resident 15's brief was soiled with drainage from the resident coccyx wound, and that after she cleaned the resident, she should have removed her gloves and washed her hands before providing any further care.</p> <p>Interview with the Director of Nursing on September 11, 2024, at 4:15 p.m. confirmed that Wound Care Nurse 2 should have removed her gloves and performed hand hygiene prior to doing any further care.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing Services.</p> |