STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395500	A. Building B. Wing	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Twin Lakes Rehabilitation and Healthcare Center	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)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, as well as resident and staff interviews, it was determined that the facility failed to maintain clinical records that were complete and accurately documented for one of four residents reviewed (Resident 1). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 1, dated April 10, 2025, revealed that the resident was understood, could understand others, had diagnosis that included hemiplegia (paralysis on one side of the body), chronic obstructive pulmonary disease (COPD - a condition caused by damage to the airways or other parts of the lung), and respiratory failure (a serious condition where the respiratory system is unable to adequately supply the body with oxygen or remove carbon dioxide), received oxygen therapy, suctioning and tracheostomy (a procedure to help air and oxygen reach the lungs by creating an opening into the trachea (windpipe) from outside the neck) care. A care plan for the resident, dated April 4, 2025, revealed that the resident has/at risk for respiratory impairment related to acute and chronic respiratory failure, hypoxia (a condition where the body, or a specific region of it, does not receive enough oxygen at the tissue level), COPD, and tracheostomy. Staff was to evaluate the resident's lung sounds and vital signs as needed and report significant changes to the physician, and obtain the resident's pulse oximetry (a test used to measure the oxygen level (oxygen saturation) of the blood) as clinically indicated and report abnormal findings. Physician's orders for Resident 1, dated April 23, 2025, revealed that Registered Nurse 1 placed orders from the physician for staff to obtain a STAT (order should be prioritized first as it is needed urgently) chest xray, complete blood count (CBC - a laboratory test that provides information about the cells in a person's blood, specifically red blood cells, white blood cells, and platelets), comprehensive metabolic panel (CMP - a blood test that assesses various aspects of your body's chemical balance and metabolism, including kidney and liver function, electrolyte levels, blood sugar, and protein levels), and sputum culture (a laboratory test that analyzes a sample of mucus (sputum) from the lungs or airways to identify bacteria, fungi, or other microorganisms that may be causing an infection) related to hypoxia. However, review of Resident 1's clinical record revealed that there was no documented evidence as to why Registered Nurse 1 obtained orders from the physician due to the resident's hypoxia on April 23, 2025. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395500	A. Building B. Wing	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Licensed Practical Nurse 2 on April 30, 2025, at 12:35 p.m. revealed that Resident 1's pulse oximetry's were running between 78 and 80 percent (a normal pulse oximeter reading for oxygen saturation is typically between 95 and 100 percent), so she suctioned the resident's tracheostomy as well as increasing her oxygen to increase the resident's pulse oximetry. She indicated that she was never able to get the resident's pulse oximetry to go above 90 percent, so she contacted Registered Nurse 1 and advised her of the resident's condition. She indicated that Registered Nurse 1 contacted the physician and received orders for the resident. Interview with Registered Nurse 1 on April 30, 2025, at 1:32 p.m. revealed that around 3:00 a.m. she went over to the [NAME] unit to obtain supplies and that she was advised by the staff on the unit that Resident 1's pulse oximetry was in the 70's, and that her heart rate was increased, so they increased her oxygen and suctioned the resident in attempts to increase the resident's pulse oximetry. They were able to get her pulse ox up into the mid 80's and her heart rate would balance around from being high to normal. She then contacted the physician and received orders from the physician for a STAT chest xray, CBC, CMP, and a sputum culture. She indicated that the physician did not give her orders to send her out at that time. She indicated that she did place a progress note in the resident's chart at that time. She indicated that she was having problems with the computers and had to go to three different computers to be able to put the physician's orders in. She indicated that she did place a progress note in the resident's clinical record. However, review of Resident 1's clinical record revealed that there was no documented evidence that Licensed Practical Nurse 2 and Registered Nurse 1 had wrote a progress note regarding the change in condition for Resident 1 on April 23, 2025. Interview with the Nursing Home Administrator and the Director of Nursing on April 30, 2025, at 2:46 p.m. confirmed that there was no documentation in Resident 1's clinical record from Licensed Practical Nurse 2 and Registered Nurse 1 regarding Resident 1's change in condition on April 23, 2025. 28 Pa Code 211.5(f) Clinical Records. 28 Pa. Code 211.12(d)(5) Nursing Services.