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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 01/02/2026 |
| 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.

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> | <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of policies, observations and staff interviews, it was determined that the facility failed to ensure residents' environment remained free of accident hazards, and failed to ensure a safe route of egress through emergency exit doors for residents on two of three units ([NAME] and [NAME] units), which placed residents in immediate jeopardy of the likelihood of serious bodily injury, harm or death. Findings include: The facility's policy regarding exits or means of egress, dated July 28, 2025, indicated that the facility had designated exits for each area of the building to allow for rapid evacuation. Exit doors would remain unlocked at all times and residents were never denied access to unlocked exits. Exit doors were to never be blocked, even briefly. The maintenance logbook for December 2025 and January 2026 revealed that the doors, locks, gates and alarms on the [NAME] and [NAME] short and long hall doors, had their operation tested daily on December 29, 30, and 31, 2025. They were marked as Pass on the logbook for these dates and there was no mention of zip ties or rolled gauze being in place. There was no documented evidence that the doors on the [NAME] and [NAME] short and long halls were checked for operation on January 1, 2026, due to the Maintenance Director being scheduled off. The instructions for checking the doors and hardware for proper operation and condition, undated, indicated that the door closures were to be checked for any obstructions and any discrepancies were to be noted. Observations on January 2, 2026, at 9:19 a.m. revealed that the two emergency doors on the short hall of the [NAME] unit had the handles to the two doors secured shut with a zip tie (self-locking plastic device), preventing egress to the outside. Interview with Licensed Practical Nurse 1 on January 2, 2026, at 9:22 a.m. revealed that she was the medication nurse on the short hall of the [NAME] unit and she was not aware that there were zip ties on the emergency exit doors preventing egress. Interview with Nurse Aide 2 on January 2, 2026, at 9:26 a.m. revealed that she was not aware that there were zip ties securing shut the emergency exit doors on the [NAME] short hall. She indicated that the wind would blow on the doors and cause the alarm to sound. Interview with the Registered Nurse Supervisor 3 on January 2, 2026, at 10:36 a.m. revealed that the wind would cause the emergency exit doors on the short hall of the [NAME] unit to alarm, but she was unaware of any exit doors being secured shut with zip ties. Observations on January 2, 2026, at 9:20 a.m. revealed that the two emergency doors on the short hall of the [NAME] unit had the handles to the two doors secured shut with a zip tie and had rolled gauze wrapped tightly around the door handles and stretched to attach to the railing adjacent to the doors preventing egress to the outside. Interview with Nurse Aide 4 on January 2, 2026, at 9:22 a.m. revealed that the emergency exit doors on the short hall of the [NAME] unit would alarm frequently due to the high winds but was not aware that the exit doors were secured shut with zip ties. Interview with the Registered Nurse 5 on January 2, 2026, at 9:26 a.m. confirmed that the emergency exit doors of the [NAME] unit were zip tied shut and had rolled gauze wrapped around the handles. She indicated that they were probably placed on the doors to prevent the alarm from going off due to the high winds that would set off the alarm. She stated that she was not usually on that unit and was unsure how long the zip ties and gauze were on the doors. Interview with Maintenance Worker 6 on January 2, 2026, at 9:42 a.m. revealed that he was not aware of any exit doors being secured with zip ties or rolled gauze. Interview with the Nursing Home Administrator on January 2, 2026, at 9:45 a.m. revealed that the wind would rattle the emergency exit doors causing the door alarm to frequently trigger, which required staff to go to the doors and re-set the alarm. He stated that he was not aware that the exit doors on the short halls of the [NAME] and [NAME] units were secured shut with zip ties and rolled gauze. He confirmed that the doors should not have been secured shut with zip ties or rolled gauze and he was unaware who applied the zip ties and rolled gauze. Interview with the Director of Nursing on January 2, 2026, at 12:36 p.m. confirmed that she was not aware that there were emergency exit doors secured shut with zip ties and gauze on the [NAME] and [NAME] units. On January 2, 2026, at 12:41 p.m. the Nursing Home Administrator was informed that the health and safety of the residents was placed in Immediate Jeopardy due to the emergency exit doors on the short halls of the [NAME] and [NAME] units being secured shut with zip ties and rolled gauze which would have prevented resident egress from the facility during an emergency. The Immediate Jeopardy template was also provided to the Nursing Home Administrator. The facility submitted and implemented an immediate action plan that included removing the zip ties and rolled gauze that secured the emergency exit doors shut, inspected all doors to ensure proper functioning, educated all staff on emergency doors and route of egress and the facility's policy that all emergency exit doors should be unobstructed, and</p> | | |

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| <p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of policies and employee job descriptions, as well as observations and staff interviews, it was determined that the facility's administration, Nursing Home Administrator and Director of Nursing, failed to effectively use its resources to promote resident safety and maintain the highest practicable physical well being of residents in the facility by failing to ensure that emergency exit doors were accessible to residents, allowing egress to the outside during an emergency situation, placing the residents at risk for serious harm which created an Immediate Jeopardy situation. Findings included: The job description for the Nursing Home Administrator, undated, revealed that the administrator's essential job functions included the planning, developing, organizing, implementing and directing of programs and activities; assuring that the facility was properly maintained, and clean and safe for resident comfort and conveniences; and implement an effective accident prevention program. The facility failed to ensure these responsibilities were carried out, as evidenced by the emergency exit doors being secured shut with zip ties and rolled gauze, ensuring that all emergency exits were accessible to residents, allowing egress during an emergency situation. This demonstrated a lack of effective oversight to address the safety of residents during an emergency situation. The job Description for the Director of Nursing, dated June 25, 2025, indicated that the Director of Nursing was responsible for the planning, developing, organizing, and directing the overall operation of the Nursing Service Department in accordance with current Federal, State, and local standards, guidelines and regulations that governed the facility; develop, maintain and periodically update written policies and procedures that govern the day to day functions of the nursing services department; monitor nursing service personnel to ensure that they are following established safety regulations in the use of equipment and supplies; and ensure that all resident care rooms, treatment areas, etc. are maintained in a clean, safe and sanitary manner. The DON failed to ensure that all emergency exit doors were accessible to residents, allowing egress to the outside during an emergency situation. Based on the findings the facility's inability to ensure that all emergency exits were accessible to residents and allowed egress during an emergency situation resulted in Immediate Jeopardy to the health and safety of residents on the [NAME] and [NAME] units. This demonstrates a systemic failure in the administration's oversight and resource allocation to ensure a safe environment for residents. The deficiency cited under the Code of Federal Regulatory Groups for Long Term Care, Quality of Care (F689) 483.25(d)(1)(2) Accidents, revealed the facility's administration did not fulfill essential job duties to ensure resident safety and regulatory compliance. This included a failure to ensure that emergency exits on the [NAME] and [NAME] units were accessible to residents and allowed egress to the outside during an emergency situation. Refer F689 28 Pa. Code: 201.14 (a) Responsibility of licensee 28 Pa. Code: 201.18 (b)(1)(3)(e)(1) Management 28 Pa. Code 211.12 (c)(d)(1)(3)(5) Nursing services</p> | | |