

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  10/09/2024
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)
<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are fully informed and understand their health status, care and treatments.</p> <p>38012</p> <p>Based on clinical record reviews and resident and staff interviews, it was determined that the facility failed to honor the resident's right to make informed choices and participate in his/her treatment for one of 61 residents reviewed (Resident 84).</p> <p>Findings include:</p> <p>A comprehensive Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 84, dated August 21, 2024, indicated that the resident could be understood and could understand others, and was alert and oriented.</p> <p>A nursing note for Resident 84, dated May 24, 2024, revealed that the resident requested to have lab work drawn.</p> <p>According to Resident 84's clinical record, she had labs drawn and resulted on May 28, 2024.</p> <p>There was no documented evidence in Resident 84's clinical record that anyone reviewed her lab results with her.</p> <p>Interview with Resident 84 on October 6, 2024, at 10:58 a.m. revealed that she requested lab work be done; however, no one reviewed the results with her.</p> <p>Interview with the Director of Nursing on October 8, 2024, at 2:00 p.m. revealed that she stated there was no documented evidence that anyone reviewed the resident's lab results with her and they should have.</p> <p>28 Pa. Code 201.29(a)(j) Resident Rights.</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 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p>31760</p> <p>Based on review of policies and clinical records, as well as observations and resident and staff interviews, it was determined that the facility failed to determine if residents were safe to self-administer medications for three of 61 residents reviewed (Residents 19, 78, 108).</p> <p>Findings include:</p> <p>The facility's medication administration policy, dated July 19, 2024, indicated that medications are administered in a safe manner, and as prescribed. Residents may self-administer their own medications only if the attending physician, in conjunction with the interdisciplinary care planning team, has determined that they have the decision-making capacity to do so safely.</p> <p>The facility's self-administration policy, dated July 19, 2024, indicated that residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so. If it is deemed safe and appropriate for a resident to self-administer medications, this is documented in the medical record and the care plan.</p> <p>A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 19, dated August 18, 2024, revealed that the resident was understood and could understand others.</p> <p>Physician's orders for Resident 19, dated August 3, 2023, included an order for the resident to receive 17 grams of polyethylene glycol (medication used to treat constipation) dissolved in four to six ounces of fluid and given daily.</p> <p>Observations during medication administration on October 7, 2024, at 7:52 a.m. revealed that Licensed Practical Nurse 1 prepared 17 grams of polyethylene glycol in a cup of four ounces of water and left the cup sitting on Resident 19's overbed table. At 8:00 a.m. and 8:12 a.m., Resident 19 was lying in her bed with no staff present and the cup of polyethylene glycol and water was sitting on her overbed table.</p> <p>Interview with Licensed Practical Nurse 1 on October 7, 2024, at 8:16 a.m. confirmed that she left the polyethylene glycol with Resident 19 and would go back and check if the resident took the medication.</p> <p>Interview with the Director of Nursing on October 7, 2024, at 10:14 a.m. confirmed that Licensed Practical Nurse 1 should have observed Resident 19 take the polyethylene glycol and should not have left it with the resident, and that there was no assessment to determine if Resident R19 was safe to self-administer her medications.</p> <p>A quarterly MDS assessment for Resident 78, dated July 29, 2024, indicated that the resident was cognitively intact, was dependent on staff for daily care needs, and had diagnoses that included hemiplegia (muscle weakness or partial paralysis on one side of the body) following a stroke (disruption in blood flow to the brain) affecting the right side.</p> <p>(continued on next page)</p>		

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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observations of Resident 78 on October 5, 2024, at 11:50 a.m. revealed the resident lying in bed and a medicine cup containing two pills was sitting on his overbed table. An interview with Resident 78 at that time revealed that he did not know the pills were on his table and that nurses will frequently leave his pills sitting there if he is sleeping when the nurse comes in to administer his medication.</p> <p>An interview with Licensed Practical Nurse 2 on October 5, 2024, at 11:54 a.m. revealed that she did leave medication in Resident 78's room because she thought he was awake and was going to take them. She did not stay in the room to observe the resident take the medication.</p> <p>A quarterly MDS assessment for Resident 108, dated September 22, 2024, indicated that the resident was usually understood and could usually understand others, required assistance from staff for daily care needs, and had diagnoses that included bipolar disorder (mental health condition that causes extreme mood swings) and presence of surgical wounds.</p> <p>Observations of Resident 108 on October 5, 2024, at 10:45 a.m. revealed the resident was lying in bed and a medicine cup containing nine clean, dry pills was sitting on her overbed table. Interview with Resident 108 at that time revealed that they were her morning medications that were left for her to take, but she had not taken them yet.</p> <p>Interview with Licensed Practical Nurse 3 on October 8, 2024, at 10:48 a.m. revealed that she gave Resident 108 her medication and she thought the resident had taken them; however, she was not observed swallowing the medication and must have spit them back out.</p> <p>An interview with the Director of Nursing on October 5, 2024, at 2:31 p.m. confirmed that medications should not have been left unsupervised at the bedside for Resident 78 or Resident 108 to take.</p> <p>An interview with the Director of Nursing on October 7, 2024, at 3:12 p.m. confirmed that there were no assessments to determine if Residents 78 or 108 could self-administer their medications.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing Services.</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>48941</p> <p>Based on review of policies and clinical records, as well as observations and resident and staff interviews, it was determined that the facility failed to ensure that call bells were within reach for one of 61 residents reviewed (Resident 59).</p> <p>Findings include:</p> <p>A review of the facility Answering the Call Light policy, dated July 19, 2024, indicated that the facility was to ensure that the call light was accessible to the resident when in bed.</p> <p>A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's care needs and abilities) for Resident 59, dated July 31, 2024, revealed that the resident was understood and able to understand others, required assistance from staff for care needs, and had diagnoses that included glaucoma (chronic eye disease that damages the optic nerve and causes vision loss) and hemiplegia/hemiparesis (paralysis or weakness to one side of the body due to brain injury) following a cerebral vascular accident (an event caused by poor blood flow or bleeding to in the areas of the brain). A fall risk care plan for Resident 59, dated October 2, 2023, indicated that the resident was at risk for falls due to his impaired vision and decline in functional mobility and had an intervention to keep his call bell in reach.</p> <p>Observation of Resident 59 on October 5, 2024, at 10:39 a.m. revealed that the resident was lying in his bed in his room and his call bell was clipped to an electrical cord at the wall behind his bedside dresser. Interview with the resident indicated that he was able to use his call bell to ring for assistance and he searched to find it.</p> <p>Interview with Nurse Aide 4 at the time of the observation confirmed that Resident 59 was able to use his call bell. She indicated that he was blind and was used to having it clipped to his blankets. She confirmed that the resident did not have his call bell within reach, and it should have been.</p> <p>Interview with the Director of Nursing on October 5, 2024, at 2:53 p.m. confirmed that Resident 59's call bell should have been within his reach.</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.</p>		

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<p>F 0578</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 request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>48941</p> <p>Based on review of clinical records, as well as staff interviews, it was determined that the facility failed to ensure that the resident and/or resident representative had an opportunity to develop an advance directive (instructions regarding the provision of health care when the resident is incapacitated) or assist in formulating an advance directive for four of 61 residents reviewed (Residents 14, 17, 59, 101).</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 14, dated August 16, 2024, indicated that the resident was clearly understood and clearly able to understand others, required assistance with care needs, and had a diagnosis of dementia.</p> <p>An annual MDS assessment for Resident 17, dated September 7, 2024, revealed that the resident was cognitively intact, was clearly understood and clearly able to understand others, required assistance for care needs, and had diagnoses that included schizophrenia (a serious mental disorder that affects how people interpret reality), anxiety, depression, and bipolar disorder (a mental disorder that causes extreme mood swings).</p> <p>A quarterly MDS assessment for Resident 59, dated July 31, 2024, revealed that the resident was clearly understood and able to clearly understand others, required assistance from staff for care needs, and had diagnoses that included glaucoma (chronic eye disease that damages the optic nerve and causes vision loss) and hemiplegia/hemiparesis (paralysis or weakness to one side of the body due to brain injury) following a cerebral vascular accident (an event caused by poor blood flow or bleeding in the areas of the brain).</p> <p>An admission MDS assessment for Resident 101, dated September 22, 2024, revealed that the resident was cognitively intact, was clearly understood and was clearly able to understand others, and required assistance with care needs.</p> <p>Review of Residents 14, 17, 59 and 101's clinical records indicated that they did not have advance directives. There was no documented evidence in the residents' clinical records that indicated the residents and/or their representative were informed of their rights to develop advance directives, no documented evidence that the residents and/or their representatives were provided the opportunity and assistance to formulate an advance directive, and no documented evidence that advanced directives were addressed with the residents and/or resident representatives periodically throughout their course of stay.</p> <p>(continued on next page)</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with the Nursing Home Administrator on October 8, 2024, at 12:14 p.m. confirmed that there was no documented evidence in Resident 14's, 17's, 59's and 101's clinical records that indicated the residents and/or their representatives were informed of their rights to develop advance directives, no documented evidence that the residents and/or their representatives were provided the opportunity and assistance to formulate an advance directive, and no documented evidence that advanced directives were addressed with the residents and/or resident representatives periodically throughout their course of stay. He confirmed that the facility was to address advance directives regularly at the care conferences, but they have not been doing that and it is something they have to work on.</p> <p>28 Pa. Code 201.29(a)(d) Resident Rights.</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>46994</p> <p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>Based on review of policies and personnel files, as well as staff interviews, it was determined that the facility failed to complete a criminal background check prior to hire for one of three nurse aides reviewed (Nurse Aide 3).</p> <p>Findings include:</p> <p>The facility's policy regarding abuse, neglect, exploitation, and misappropriation prevention, dated July 19, 2024, indicated that the facility will conduct employee background checks and will not knowingly employ any individual who has been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law.</p> <p>Review of the personnel file for Nurse Aide 3 revealed that he was hired on June 6, 2024, but as of October 8, 2024, there was no evidence that a criminal background check was completed.</p> <p>Interview with the Human Resource Director on October 8, 2024, at 2:30 p.m. confirmed that there was no documented evidence that a criminal background check was completed for Nurse Aide 3 prior to his date of hire.</p> <p>28 Pa. Code 201.14(a) Responsibility of Licensee.</p> <p>28 Pa. Code 201.18(e)(1) Management.</p>		

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>19102</p> <p>Based on clinical record reviews and staff interviews, it was determined that the facility failed to notify the resident and resident's representative in writing of the transfer and reason for hospitalization for four of 61 residents reviewed (Residents 13, 88, 109, 131). This deficiency was cited as past noncompliance.</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 13, dated August 23, 2024, indicated that the resident was cognitively intact, required assistance from staff for care needs, had an indwelling catheter (a thin, flexible tube inserted into the bladder to drain urine from the bladder), received dialysis (treatment to remove extra fluid and waste from the blood when the kidneys are not able to), and had diagnoses that included neurogenic dysfunction of the bladder (bladder lacks control due to nerve or muscle problems) and End-Stage Renal Disease (kidneys no longer work as they should to meet the body's needs requiring dialysis or kidney transplant).</p> <p>A nursing note, dated August 15, 2024, at 7:25 a.m. revealed that the facility received a phone call from the dialysis center reporting that Resident 13 was experiencing increased lethargy and was slumping over to the side. The physician was notified, and the resident was transferred to the hospital for evaluation.</p> <p>There was no documented evidence that a written notice of Resident 13's transfer to the hospital was provided to the resident's representative regarding the reason for transfer.</p> <p>A quarterly MDS assessment for Resident 88, dated August 19, 2024, indicated that the resident was cognitively impaired, required assistance from staff for daily care tasks, and had a feeding tube.</p> <p>A nursing note, dated August 12, 2024, at 5:54 p.m. revealed that Resident 88 had a large emesis with curdled feeding and a red-colored liquid, appearing to be blood. The physician was notified, and the resident was transferred to the hospital for evaluation.</p> <p>There was no documented evidence that a written notice of Resident 88's transfer to the hospital was provided to the resident's representative regarding the reason for transfer.</p> <p>A quarterly MDS assessment for Resident 109, dated August 17, 2024, revealed that the resident was cognitively impaired, required assistance from staff for daily care tasks, had diagnoses that included aphasia (a language disorder that affects a person's ability to understand and express written and spoken language), Parkinson's disease, seizures, and tracheostomy (a surgical procedure that creates an opening in the neck to provide an airway and help with breathing), and had a feeding tube.</p> <p>(continued on next page)</p>		

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Nursing notes for Resident 109, dated February 12, 2024, revealed that the writer was notified by nursing staff that the resident was presenting with increased lethargy (a state of tiredness, sleepiness, weariness, fatigue, sluggishness, or lack of energy). The physician was notified of the resident's change in condition. New orders were received to transfer the resident to the emergency department for further evaluation. The resident was admitted to the intensive care unit with a diagnosis of hyponatremia (a condition where the level of sodium in the blood is lower than normal), fever, acute kidney injury (a sudden decrease in kidney function that can range from mild to severe), and respiratory distress (a condition that occurs when the body needs more oxygen, resulting in difficulty breathing and low oxygen levels in the blood).</p> <p>Nursing notes for Resident 109, dated March 28, 2024, revealed that the writer was alerted to the resident's room by the staff nurse who noted a fever, alerted mental status, and increased oxygen demand. The physician was notified, and orders were received to send the resident to the emergency department for further evaluation. The resident was admitted with the diagnosis of shortness of breath, urinary tract infection, altered mental status, fever, aspiration pneumonia (a lung infection that occurs when you inhale food, liquid, or other substances into the lungs instead of swallowing them), and hyperkalemia (a condition where there is too much potassium in the blood).</p> <p>Nursing notes for Resident 109, dated May 14, 2024, revealed that the writer was notified by nursing that the resident was presenting hypoxia (a condition that occurs when the body or a part of the body does not have enough oxygen at the tissue level). The physician was notified, and orders were received to send the resident to the emergency department for further evaluation. The resident was admitted with a diagnosis of sepsis (a serious condition in which the body responds improperly to an infection), acute respiratory failure with hypoxia, and bilateral pneumonia.</p> <p>Nursing notes for Resident 109, dated June 27, 2024, revealed that the nurse was in the resident's room administering morning medications when the nurse found the resident with agonal breathing (when someone who is not getting enough oxygen is gasping for air). The nurse and the respiratory therapist stayed with the resident until the ambulance arrived, and the resident was transferred to the emergency department. The resident was admitted with the diagnosis of sepsis, acute kidney injury, hyponatremia, hyperkalemia, and anemia (a blood disorder that happens when there is not enough red blood cells or the red blood cells do not work as they should).</p> <p>A nursing note for Resident 109, dated August 6, 2024, revealed that the resident was admitted to the intensive care unit with a diagnosis of sepsis, respiratory failure, hyponatremia, and requiring mechanical ventilation.</p> <p>There was no documented evidence that a written notice of Resident 109's transfers to the hospital were provided to the resident's representative regarding the reason for transfer.</p> <p>An admission MDS assessment for Resident 131, dated February 27, 2024, revealed that the resident was cognitively intact, required assistance from staff for daily care needs, used oxygen, and had diagnoses that included respiratory failure.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 19102</p> <p>Based on review of the Resident Assessment Instrument User's Manual and clinical records, as well as staff interviews, it was determined that the facility failed to complete accurate Minimum Data Set assessments for seven of 61 residents reviewed (Residents 6, 13, 51, 78, 80, 88, 128).</p> <p>Findings include:</p> <p>The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which provides guidance and instructions for the completion of Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated October 2023, indicated that Section N0415 (high risk drug classes) E (anticoagulant) was to be coded (1) is taking, if an anticoagulant (blood thinner) medication was administered while a resident at the facility during the seven-day assessment period.</p> <p>Physician's orders for Resident 6, dated April 17, 2024, included for the resident to receive 75 milligrams (mg) of Pradaxa (an anticoagulant) two times a day.</p> <p>Review of the Medication Administration Record (MAR) for Resident 6, dated August 2024, revealed that the resident was administered 75 mg of Pradaxa twice a day during all seven days of the seven-day assessment period.</p> <p>A quarterly MDS assessment for Resident 6, dated August 22, 2024, revealed that Section N0415E was not coded (1), indicating that the resident did not receive an anticoagulant medication during the seven-day assessment period.</p> <p>Interview with the Registered Nurse Assessment Coordinator on October 9, 2024, at 9:34 a.m. confirmed that Resident 6's quarterly MDS assessment was coded incorrectly and should have been coded to indicate that the resident was receiving an anticoagulant medication during the seven-day assessment period.</p> <p>The Long-Term Care Facility RAI User's Manual, dated October 2023, indicated that Section O0110H1, intravenous (IV) (administration of medications directly into a person's vein) medications, was to be coded for any drug or biological given by intravenous push, epidural pump, or drip through a central or peripheral port at any time during the seven-day look back period. It indicated not to code IV medications of any kind that were administered during dialysis or chemotherapy.</p> <p>Physician's orders for Resident 13, dated August 22, 2024, included an order for the resident to receive two grams of Vancomycin HCl intravenously daily every Tuesday, Thursday, and Saturday for seven administrations with indications to send the medication to dialysis to be administered at dialysis.</p> <p>Review of the MAR for Resident 13, dated August 2024, revealed that the resident was not administered two grams of Vancomycin HCl intravenously during the seven-day assessment period.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Twin Lakes Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  227 Sand Hill Road Greensburg, PA 15601	

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<p>F 0641</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 13, dated August 23, 2024, revealed that Section O0110H1 was coded indicating that the resident received an IV medication while a resident during the seven-day look back period.</p> <p>Interview with the Registered Nurse Assessment Coordinator on October 9, 2024, at 10:25 a.m. confirmed that Resident 13's quarterly MDS assessment was coded incorrectly and should not have been coded to indicate that the resident received an IV medication during the seven-day assessment period.</p> <p>The Long-Term Care Facility RAI User's Manual, dated October 2023, indicated that Section O0110C1, oxygen therapy, was to be coded if oxygen was administered at any time during the seven-day look back period.</p> <p>Review of the MAR for Resident 51, dated September 2024, revealed that the resident did not receive oxygen during the seven-day assessment period.</p> <p>A quarterly MDS assessment for Resident 51, dated September 24, 2024, revealed that Section O0110C1 was coded indicating that the resident received oxygen therapy during the seven-day look back period.</p> <p>Interview with the Registered Nurse Assessment Coordinator on October 9, 2024, at 10:25 a.m. confirmed that Resident 51's quarterly MDS assessment was coded incorrectly and should not have been coded to indicate that the resident received oxygen therapy during the seven-day assessment period.</p> <p>The Long-Term Care Facility RAI User's Manual, dated October 2023, revealed that Section E (Behavior) 0800 (rejection of care) was to be checked (0) if the behavior was not exhibited, (1) if it occurred one to three days, (2) if it occurred four to six days but less than daily, or (3) behavior occurred daily.</p> <p>Review of nurse aide documentation for Resident 78, dated July 2024, revealed that the resident refused dressing on July 27; refused to get out of bed on July 24, 27, 28, and 29; refused a shower on July 27; refused wheelchair use on July 25 and July 26; and refused a meal on July 24 and 27.</p> <p>A quarterly MDS assessment for Resident 78, dated July 29, 2024, revealed that Section E0800 was checked (0), indicating that the resident did not exhibit any rejection of care during the seven-day assessment period.</p> <p>Interview with the Registered Nurse Assessment Coordinator on October 9, 2024, at 9:42 a.m. confirmed that Resident 78's quarterly MDS assessment was coded incorrectly and should have been coded to indicate that the resident had exhibited rejection of care during the seven-day assessment period.</p> <p>The Long-Term Care Facility RAI User's Manual, dated October 2023, revealed that Section N0415H (opioid) was to be checked (1) is taking, if an opioid (a class of drugs used to reduce moderate to severe pain) medication was administered while a resident at the facility during the seven-day assessment period.</p> <p>Physician's orders for Resident 80, dated August 14, 2024, included for the resident to receive 50 mg of Tramadol (narcotic pain reliever) two times a day for pain.</p> <p>(continued on next page)</p>

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Medication Administration Record (MAR) for Resident 80, dated September 2024, revealed that the resident was administered 50 mg of Tramadol twice a day during all seven days of the seven-day assessment period.</p> <p>An annual MDS assessment for Resident 80, dated August 8, 2024, revealed that Section N0415H was not checked (1), indicating that the resident did not receive an opioid medication during the seven-day assessment period.</p> <p>Interview with the Registered Nurse Assessment Coordinator on October 9, 2024, at 9:34 a.m. confirmed that Resident 80's annual MDS assessment was coded incorrectly and should have been coded to indicate that the resident was receiving an opioid medication during the seven-day assessment period.</p> <p>The Long-Term Care Facility RAI User's Manual, dated October 2023, revealed that Section N0415H1 should be checked if the resident received an opioid medication during the seven-day assessment period.</p> <p>Physician's orders for Resident 88, dated August 17, 2024, included an order for the resident to receive 50 mg of Tramadol (narcotic pain reliever) every four hours as needed for moderate pain (pain scale 4-6 out of 10), and the resident's MAR for August 2024 revealed that she received Tramadol on August 17, 2024. However, a quarterly MDS assessment, dated August 19, 2024, revealed that Section N0410H was coded with a zero (0), indicating that the resident did not receive an opioid during the review period.</p> <p>Interview with the the RNAC on October 9, 2024, at 9:34 a.m. confirmed that Resident 88's annual MDS assessment was coded incorrectly.</p> <p>The RAI User's Manual, dated October 2019, indicated that the intent of Section A was to record the discharge status of the resident. Section A2100 was to be coded with the location of the resident's discharge.</p> <p>A nursing note for Resident 128, dated August 8, 2024, indicated that the resident was discharged to home on that date. However, a discharge tracking MDS, dated [DATE], indicated that Resident 128 was discharged to the hospital.</p> <p>An interview with the Director of Nursing on October 9, 2024, confirmed that Resident 128 was discharged home/to the community and not to the hospital. She confirmed that the wrong discharge location was entered on Resident 128's discharge tracking MDS.</p> <p>28 Pa. Code 211.5(f) Clinical Records.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>38012</p> <p>Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to develop care plans to address individualized resident care needs for two of 61 residents reviewed (Residents 70, 80).</p> <p>Findings include:</p> <p>The facility's policy regarding care plans, dated July 19, 2024, revealed that a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented on each resident. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions changes.</p> <p>A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 70, dated August 5, 2024, revealed that the resident was cognitively intact and was receiving an anti-coagulant (blood thinner).</p> <p>Physician's orders for Resident 70, dated March 8, 2024, included an order for the resident to receive 10 milligrams (mg) of Xarelto (blood thinner) once a day.</p> <p>There was no documented evidence that a care plan was developed to address Resident 70's care needs related to the use of an anticoagulant.</p> <p>Interview with Director of Nursing on October 8, 2024, at 10:18 a.m. confirmed that Resident 70 did not have a care plan to address his care needs related to the use of an anticoagulant.</p> <p>An annual MDS assessment for Resident 80, dated September 8, 2024, indicated that the resident had moderate cognitive impairment, was dependent on staff for daily hygiene needs, had an indwelling catheter (a thin hollow tube inserted into the bladder to drain urine), had an ostomy (opening that is created surgically somewhere on the body), and had diagnosis that included urinary tract infection and obstructive uropathy (condition in which the flow of urine is blocked).</p> <p>Review of a hospital discharge summary for Resident 80, dated August 9, 2024, revealed that the resident had a right nephrostomy (thin catheter that drains urine from the kidney into a bag) placement on July 18, 2024.</p> <p>As of October 8, 2024, there was no documented evidence that a care plan was developed to address Resident 80's individualized care needs related to the care and treatment to his nephrostomy.</p> <p>Interview with the Director of Nursing on October 8, 2024, at 1:40 p.m. confirmed that Resident 80 did have a nephrostomy and a care plan was not developed to address the care and treatment required for his nephrostomy.</p> <p>28 Pa. Code 211.10(d) Resident Care Plans.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>46994</p> <p>Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that a resident's care plan was updated/revised to reflect the resident's specific care needs for two of 61 residents reviewed (Residents 51, 80).</p> <p>Findings include:</p> <p>The facility's policy regarding care plans, dated July 19, 2024, revealed that a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented on each resident. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change.</p> <p>A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 51, dated September 24, 2024, indicated that the resident was cognitively intact, was understood and able to understand others, and required assistance with care needs.</p> <p>A physician's note for Resident 51, dated August 15, 2024, at 11:29 p.m., revealed that the resident requested that his Eliquis (an anticoagulant- medication used to thin the blood to prevent blood from clotting) be discontinued due to a one-time history of deep vein thrombosis. The practitioner documented that his symptoms resolved a long time ago upon initiating Eliquis . Recommendations at that time indicated to discontinue the Eliquis and start Aspirin (an antiplatelet- medication used to prevent blood from clotting).</p> <p>Review of Resident 51's Medication Administration Record for October 2024 revealed that the resident was not ordered an anticoagulant medication. An anticoagulant therapy care plan for Resident 51, dated July 12, 2024, indicated that the resident was taking an anticoagulant medication.</p> <p>Interview with Director of Nursing on October 8, 2024, at 12:14 p.m. confirmed that Resident 51's care plan for anticoagulation therapy should have been resolved to reflect that the anticoagulant medication was discontinued.</p> <p>An annual MDS assessment for Resident 80, dated September 8, 2024, indicated the resident had moderate cognitive impairment, was dependent on staff for daily hygiene needs, had an indwelling catheter (flexible tube that drains urine from the bladder into a bag outside the body), and had diagnoses that included urinary tract infection and obstructive uropathy (condition in which the flow of urine is blocked).</p> <p>Physician's orders for Resident 80, dated August 14, 2024, included an order for an indwelling catheter for a diagnosis of obstructive uropathy.</p> <p>An active care plan for Resident 80, dated April 1, 2024, indicated that the resident had an indwelling foley catheter. An active care plan for Resident 80, dated June 11, 2024, indicated that the resident was incontinent of urine.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observations of Resident 80 on October 5, 2024, at 11:50 a.m. revealed that the resident was lying in bed with a urinary drainage bag attached to his bed frame.</p> <p>Interview with The Director of Nursing on October 8, 2024, at 1:40 p.m. revealed that as of October 8, 2024, Resident 80 had an active care plan for urinary incontinence and a foley catheter. The care plan was not revised when the resident was ordered a foley catheter and continued to indicate that the resident had urinary incontinence when it should not have.</p> <p>28 Pa. Code 201.24(e)(4) Admission Policy.</p> <p>28 Pa. Code 211.12(d)(5) Nursing Services.</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>46994</p> <p>Based on policy review, observations, and staff interviews, it was determined that the facility failed to ensure care and services were provided in accordance with professional standards regarding medication administration for two of 61 residents reviewed (Residents 47, 77).</p> <p>Findings include:</p> <p>Review of the facility policy for medication administration, dated July 19, 2024, revealed that medications are administered in a safe and timely manner and as prescribed. The Director of Nursing supervises and directs all personnel who administer medications and/or have relate functions. The individual administering the medication initials the residents Medication Administration Record on the appropriate line after giving each medication and before administering the next ones.</p> <p>Observations during medication administration on October 7, 2024, at 7:34 a.m. revealed that Licensed Practical Nurse 2 prepared medications for Resident 47 then picked up the medicine cup with the medications that she had just prepared, and another medicine cup with pills in that was prepared prior to the surveyor observation, and proceeded into the residents' room. Licensed Practical Nurse 2 handed Resident 77 her medications and watched her take them, then proceeded directly to Resident 47 and assisted her to take her medication.</p> <p>An interview with Licensed Practical Nurse 2 immediately after the medication administration revealed that Licensed Practical Nurse 2 knew she should not have administered medications to both residents at the same time. She reported that she should have prepared and administered the medication for one resident at a time as she usually does.</p> <p>Interview with the Director of Nursing on October 7, 2024, at 3:12 p.m. confirmed that Licensed Practical Nurse 2 should have prepared and administered medication for one resident at a time and should not have administered medications to two residents at the same time.</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>46994</p> <p>Based on clinical record reviews, as well as staff and resident interviews, it was determined that the facility failed to ensure that residents were provided with showers/baths as scheduled for two of 61 residents reviewed (Residents 36, 68).</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 36, dated August 22, 2024, revealed that the resident was cognitively intact, was dependent on staff for bathing/showering, and had diagnoses that included rheumatoid arthritis (chronic disease that causes inflammation around the body and commonly presents with pain in the joints).</p> <p>Resident 36's bathing record for August and September 2024 revealed that the resident was to receive a shower every Monday during the evening shift and every Friday during the day shift; however, documentation during that time revealed that the resident was provided a bed bath on Mondays and Thursdays on day shift, with the exception of a shower provided on August 19, 2024; September 19, 2024; and September 30, 2024. No showers were offered or refused on the evening shift.</p> <p>Interview with Resident 36 on October 5, 2024, at 10:30 a.m. during initial rounds revealed that the resident was not getting her showers as preferred because staff would either not offer her a shower or they provided excuses for not being able to provide a shower, like no hot water was available.</p> <p>Interview with the Director of Nursing on October 8, 2024, at 11:55 a.m. confirmed that showers were not being provided to Resident 36 per her preference.</p> <p>A quarterly MDS assessment for Resident 68, dated July 22, 2024, revealed that the resident was cognitively intact, required partial to maximum assist with bathing/showers, and had a diagnosis which included traumatic brain injury (brain dysfunction caused by an outside force, usually a violent blow to the head).</p> <p>Resident 68's bathing records, dated September 1, 2024, through October 8, 2024, revealed that the resident was to receive a shower every Monday on daylight shift and every Friday on evening shift; however, documentation during that time revealed that the resident was only provided a shower on Mondays. No showers were offered or refused any other day of the week.</p> <p>Interview with Resident 68 on October 8, 2024, at 10:15 a.m. during initial rounds revealed that the resident requested to have showers twice a week but was only getting one shower a week.</p> <p>Interview with the Director of Nursing on October 7, 2024, at 10:39 a.m. confirmed that showers were only being provided to Resident 68 once a week when he preferred to have showers twice a week.</p> <p>28 Pa. Code 211.12(d)(5) Nursing Services.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46994</p> <p>Based on clinical record reviews and staff interviews, it was determined that the facility failed to ensure that physician's orders regarding treatment administration were followed for one of 61 residents reviewed (Resident 80).</p> <p>Findings include:</p> <p>An annual Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 80, dated September 8, 2024, indicated that the resident had moderate cognitive impairment, was dependent on staff for personal hygiene care, had diagnoses that included urinary tract infection and diabetes, and had one Stage 4 pressure ulcer (wound that occurs from prolonged pressure on the skin that that involves full thickness tissue loss with exposed bone, tendon, or muscle).</p> <p>Physician's orders for Resident 80, dated September 19, 2024, included orders to remove the resident's dressing, re-evaluate the wound, and contact the provider to obtain new orders for wound care any time the resident's negative wound pressure therapy (NWPT- treatment that pulls fluid and bacteria out of a wound to help it heal better) is off for over two hours.</p> <p>An orders-administration note for Resident 80, dated October 7, 2024, at 12:31 p.m., revealed that the resident's NWPT treatment was not administered because there was no tubing available for the canister, and that an abdominal pad was applied to the resident's wound. Observations of Resident 80 on October 8, 2024, at 8:23 a.m. revealed the resident was in bed. His NWPT treatment device was sitting on his bedside table and was not turned on. There was no documented evidence that the resident's provider was notified that Resident 80's NWPT treatment was off for more than two hours.</p> <p>Interview with Licensed Practical Nurse 6 on October 8, 2024, at 8:23 a.m. confirmed that Resident 80's NWPT treatment was not attached and functioning, and she was unsure why.</p> <p>Interview with the Director of Nursing on October 8, 2024, at 11:58 a.m. confirmed that the physician was not notified on October 7, 2024, when the resident's NWPT treatment was not functioning for greater than two hours as ordered.</p> <p>A skin and wound note for Resident 80, dated September 3, 2024, at 2:47 p.m., revealed that the resident had a medical adhesive related skin injury (MARSi) above his nephrostomy (thin catheter that drains urine from the kidney into a bag) and new orders were obtained for Xeroform (a petrolatum-based fine mesh gauze) and a border foam dressing (absorbent wound covering).</p> <p>Review of Resident 80's Treatment Administration Record (TAR) for September 2024 revealed no documented evidence that the treatment to his MARSi was completed as ordered.</p> <p>Interview with the Director of Nursing on October 8, 2024, at 1:40 p.m. confirmed that Resident 80's treatment to the [NAME] above his nephrostomy was never administered and should have been.</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing Services.</p>		

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<p>F 0685</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assist a resident in gaining access to vision and hearing services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48941</b></p> <p>Based on review of clinical records, as well as resident, family, and staff interviews, it was determined that the facility failed to ensure that residents had proper assistive devices to maintain adequate hearing for one of 61 residents reviewed (Resident 14).</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 14, dated [DATE], indicated that the resident was understood and able to understand others and required assistance with daily care needs. Resident 14's care plan, dated [DATE], revealed that she had difficulty communicating and used hearing aids.</p> <p>A social services note, dated [DATE], at 11:56 a.m., indicated that Resident 14's right hearing aid was smashed and audiology took both hearing aids in an attempt to fix/replace them.</p> <p>An audiology consult note, dated [DATE], indicated that the right hearing aid was smashed and both hearing aids were taken for repair.</p> <p>Interview with Resident 14 on [DATE], during the initial tour revealed that she needed a new pair of hearing aids. She indicated that they were taken away, and she had not heard anything for a while. Observations during the interview revealed that the resident did not have any hearing aids in her ears and was difficult to communicate with her because she was hard of hearing.</p> <p>Interview with Social Worker 7 on [DATE], at 10:32 a.m. revealed that Resident 14's hearing aids were sent with the audiologist for repair. She had an email from the audiologist, dated [DATE], at 10:46 a.m., that indicated the warranty had expired in [DATE], and she did not believe that Medical Assistance would pay for repairs. Social Worker 7 responded to the audiologists email indicating that she would ask the business office.</p> <p>Interview with the Business Office Manager on [DATE], at 11:50 a.m. revealed that she was unaware of Resident 14's need for new hearing aids. She indicated that she would have to check and see if the resident could enroll with 360 audiology services to get a new pair but was not sure if this would be feasible due to the resident's limited funds and having no family support. She indicated that if the resident could not get enrolled with 360 services, she would have to wait until Medicaid would pay for another pair.</p> <p>Interview with the Social Services Director on [DATE], at 2:32 p.m. revealed that she forgot to follow up with the audiologist about the broken hearing aids. She spoke to the audiologist today and was told that she was unable to fix the hearing aids. The Social Services Director indicated that she asked the audiologist to send an invoice, and she was going to submit it to the facility to see if they could get Resident 14 a new pair of hearing aids.</p> <p>28 Pa. Code 201.29(j) Residents Rights.</p> <p>28 Pa. Code 211.12(d)(3)(5) Nursing Services.</p>		

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NAME OF PROVIDER OR SUPPLIER  Twin Lakes Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 227 Sand Hill Road Greensburg, PA 15601	
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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>19102</p> <p>Based on a review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to provide appropriate care to ensure that interventions were in place to prevent urinary tract infections for three of 61 residents reviewed (Residents 13, 80, 104) who had indwelling urinary catheters.</p> <p>Findings include:</p> <p>The facility policy for urinary catheter care, dated July 19, 2024, indicated that the catheter tubing and drainage bag were to be kept off the floor, and staff were to document the date and time that catheter care was given.</p> <p>A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 13, dated August 23, 2024, indicated that the resident was cognitively intact, required assistance from staff for care needs, had an indwelling catheter (a thin, flexible tube inserted into the bladder to drain urine from the bladder), and had a diagnosis that included neurogenic dysfunction of the bladder (bladder lacks control due to nerve or muscle problems).</p> <p>Nurse aide documentation for Resident 13 for August and October 2024 revealed that catheter care was to be provided every shift; however, there was no documented evidence that catheter care was provided during the day shift on August 12, October 6, and October 7, 2024.</p> <p>Interview with the Director of Nursing on October 8, 2024, at 11:20 a.m. confirmed that there was no documented evidence that catheter care was provided for Resident 13 on the above-mentioned dates and shifts.</p> <p>An annual MDS assessment for Resident 104, dated August 28, 2024, revealed that the resident was cognitively impaired, had an indwelling urinary catheter (a flexible tube inserted and held in the bladder to drain urine), and had diagnoses that included a stroke and obstructive uropathy (when urine cannot drain through the urinary tract). Physician's orders for Resident 104, dated October 4, 2024, included an order for the resident to have an indwelling urinary catheter due to having obstructive uropathy.</p> <p>Observations of Resident 104 on October 5, 2024, at 10:37 a.m. and 10:48 a.m. revealed that the resident was in bed and his catheter collection bag was in direct contact with the floor. Staff entered the resident's room without repositioning the catheter bag.</p> <p>Interview with the Assistant Director of Nursing on October 5, 2024, at 10:48 a.m. confirmed that the resident's catheter drainage bag was in contact with the floor and should not have been.</p> <p>Nurse aide documentation for Resident 104 for August, September, and October 2024 revealed that catheter care was to be provided every shift; however, there was no documented evidence that catheter care was provided during the day shift on September 27; the evening shift on August 2 and 21, and September 11, 18, 24, and 27; and the night shift on October 5, 2024.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview with the Director of Nursing on October 8, 2024, at 9:13 a.m. confirmed that there was no documented evidence that catheter care was provided on the dates and times mentioned above and it should have been done.</p> <p>A facility policy for the care of a nephrostomy tube, dated July 19, 2024, indicated in part that the resident should be assessed for indications of bleeding in the flank area every eight hours, placement of the tubing should be checked during assessments, the drainage bag should be emptied once per shift, the drainage bag should be changed monthly or as needed, and output should be measured every eight hours.</p> <p>An annual MDS assessment for Resident 80, dated September 8, 2024, indicated the resident had moderate cognitive impairment, was dependent on staff for daily hygiene needs, had an indwelling catheter (a thin hollow tube inserted into the bladder to drain urine), had an ostomy (opening that is created surgically somewhere on the body), and had diagnoses that included urinary tract infection and obstructive uropathy (condition in which the flow of urine is blocked).</p> <p>Review of a hospital discharge summary for Resident 80, dated August 9, 2024, revealed that the resident had a right nephrostomy (thin catheter that drains urine from the kidney into a bag) placement on July 18, 2024.</p> <p>A review of the clinical record revealed no documented evidence that physician's orders were obtained for the care and treatment of Resident 80's nephrostomy.</p> <p>Interview with the Director of Nursing on October 8, 2024, at 1:40 p.m. confirmed that Resident 80 had no orders in place to address the care and treatment of Resident 80's nephrostomy.</p> <p>28 Pa. Code 211.12(d)(3)(5) Nursing Services.</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>19102</p> <p>Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that physician's orders were followed for two of 61 residents reviewed (Residents 88, 109) who had a feeding tube.</p> <p>Findings include:</p> <p>The facility policy regarding enteral tube feedings, dated July 19, 2024, indicated that prior to the administration of the tube feeding, staff were to verify the placement of the feeding tube and were to document the verification of the tube placement.</p> <p>A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 88, dated August 19, 2024, indicated that the resident was cognitively impaired, required assistance from staff for daily care tasks, and had a feeding tube. A care plan, dated January 15, 2024, revealed that staff were to check feeding tube placement and residuals per the guidelines or physician's order.</p> <p>Physician's orders for Resident 88, dated August 16, 2024, included orders for the resident to receive Jevity 1.5 cal (a tube feeding formula) continuously at 60 milliliters (mL) per hour 24 hours per day via a feeding tube pump and staff were to check placement of the feeding tube by checking the residual (fluid/contents that remain in the stomach) one time day. If the residual was 150 mL or less, staff were to reinsert the volume into the stomach and continue the feeding, and if the residual was greater than 150 mL, staff were to hold the tube feeding and notify the physician.</p> <p>The Medication Administration Records (MAR's) for Resident 88 for August, September, and October 2024 revealed that staff verified placement of the feeding tube; however, there was no documentation of the amount of residual that was present when verifying the tube placement.</p> <p>Interview with the Director of Nursing on October 8, 2024, at 9:44 a.m. confirmed that staff were not documenting the amount of residual that was present when checking for Resident 88's tube placement and they should have been.</p> <p>A quarterly MDS assessment for Resident 109, dated August 17, 2024, revealed that the resident was cognitively impaired, required assistance from staff for her daily care tasks, and had a feeding tube. A care plan for the resident, dated January 15, 2024, revealed that staff were to check feeding tube placement and residuals per the guidelines or physician's order.</p> <p>Physician's orders for Resident 109, dated September 16, 2024, included an order for the resident to receive Glucerna 1.5 (a tube feeding formula) at a rate of 330 ml every six hours via a feeding tube pump.</p> <p>(continued on next page)</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Physician's orders for Resident 109, dated August 16, 2024, included an order for staff to check placement of the feeding tube by checking the residual one time a day. If the residual was 150 mL or less, staff were to reinsert the volume into the stomach and continue the feeding, and if the residual was greater than 150 mL, staff were to hold the tube feeding and notify the physician.</p> <p>The MAR's for Resident 109 for August, September, and October 2024 revealed that staff verified placement of the feeding tube; however, there was no documentation of the amount of residual that was present when verifying the tube placement.</p> <p>Interview with the Director of Nursing on October 8, 2024, at 1:40 p.m. confirmed that staff were not documenting the amount of residual that was present when checking for Resident 109's tube placement and they should have been.</p> <p>28 Pa. Code 211.12(d)(3)(5) Nursing Services.</p>

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<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide for the safe, appropriate administration of IV fluids for a resident when needed.</p> <p>19102</p> <p>Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that long-term intravenous catheters were flushed per facility policy for three of 61 residents reviewed (Residents 101, 104, 136).</p> <p>Findings include:</p> <p>The facility's policy regarding the flushing of peripheral and midline intravenous catheters (a catheter that is placed in a peripheral vein for long-term administration of fluids and/or medication), dated July 19, 2024, indicated that the peripheral or midline catheter was to be flushed with 10 cubic centimeters (cc's) of normal saline (sterile salt and water solution) before and after each use.</p> <p>An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 101, dated September 22, 2024, indicated that the resident was cognitively intact, was understood and able to understand others, required assistance with care needs, received an intravenous medication, and had an infection to his left shoulder.</p> <p>Physician's orders for Resident 101, dated September 16, 2024, indicated that the resident was to have his intravenous catheter site transparent dressing changed every Monday on the day shift and as needed with instructions to indicate the external catheter length and circumference of the upper arm (10 centimeters above the antecubital) and notify the practitioner if the external length had changed from the previous measurement.</p> <p>Review of the Medication Administration Record (MAR) for Resident 101 for September and October 2024 revealed that there was no documented evidence that the external catheter length and circumference of the upper arm was measured as ordered on September 23 and September 30, 2024, and October 7, 2024.</p> <p>Interview with the Director of Nursing on October 8, 2024, at 12:03 p.m. confirmed that there was no documented evidence that Resident 101's external catheter length and upper arm circumference was measured as ordered on the above-mentioned dates.</p> <p>An annual MDS assessment for Resident 104, dated August 28, 2024, indicated that the resident was cognitively impaired and had diagnoses that included a stroke. Physician's orders for Resident 104, dated October 4, 2024, included an order for the resident to receive 2 grams of Meropenem solution (an antibiotic) intravenously every eight hours for sepsis (a life-threatening complication of an infection) for 12 administrations.</p> <p>Review of the MAR for Resident 104 for October 2024 revealed that the resident received IV Meropenem every eight hours from October 5 through 7, 2024; however, there was no documented evidence that the resident's IV catheter was flushed before and after receiving the medication per the facility's policy.</p> <p>(continued on next page)</p>		

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<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An admission MDS assessment for Resident 136, dated September 29, 2024, indicated that the resident was cognitively intact, had a PICC line (peripherally inserted central catheter- soft tube inserted into a peripheral vein for long term venous access), received intravenous antibiotics, and had diagnoses that included a multidrug resistant organism infection. Physician's orders for Resident 136, dated September 24, 2024, included an order for the resident to have a PICC line and receive 2 grams of Ceftriaxone solution (an antibiotic) intravenously every day for osteomyelitis (bone infection) until October 17, 2024.</p> <p>Review of the MAR for Resident 136 for September and October 2024 revealed that the resident received IV Ceftriaxone every day from September 24 through October 7, 2024; however, there was no documented evidence that the resident's PICC line was flushed before and after receiving the medication per the facility's policy.</p> <p>Interview with the Director of Nursing on October 8, 2024, at 1:39 p.m. confirmed that there was no documented evidence that Resident 104 or 136's peripheral IV and PICC line were flushed before and after its use for medication administration per facility policy.</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.</p>		

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<p>F 0699</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care or services that was trauma informed and/or culturally competent.</p> <p>19102</p> <p>Based on review of facility policies and clinical records, as well as staff interview, it was determined that the facility failed to ensure that residents were assessed and received trauma-informed care to eliminate or mitigate triggers for residents with the diagnosis of Post Traumatic Stress Disorder for one of 61 residents reviewed (Resident 113).</p> <p>Findings include:</p> <p>The facility's policy regarding trauma informed care, dated July 19, 2024, indicated that the facility would perform universal screenings of residents, which included a brief, non-specialized identification of possible exposures to traumatic events. The assessment involved an indepth process of evaluating the presence of symptoms, their relationship to trauma, as well as the identification of triggers.</p> <p>A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 113, dated September 20, 2024, indicated that the resident was cognitively intact, required assistance from staff for daily care needs, and had diagnoses that included anxiety, depression, Post Traumatic Stress Disorder (PTSD- a mental and behavioral disorder that develops related to a terrifying event), and schizophrenia (mental health condition that affects how people think, feel and behave). A review of Resident 113's care plan, dated September 3, 2024, indicated that the resident had anxiety, depression, PTSD, and schizophrenia.</p> <p>There was no documented evidence the facility identified Resident 113's specific triggers that could re-traumatize the resident or implement measures as to how facility staff could prevent or minimize triggers from occurring.</p> <p>Interview with the Director of Nursing on October 9, 2024, at 11:41 a.m. revealed that the facility did not complete a trauma informed care assessment for Resident 113.</p> <p>28 Pa Code 211.12(a)(d)(3)(5) Nursing Services.</p> <p>28 Pa. Code 211.16(a) Social Services.</p>		

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<p>F 0712</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that the resident and his/her doctor meet face-to-face at all required visits.</p> <p>48941</p> <p>Based on review of clinical records, as well as staff interviews, it was determined that the facility failed to ensure that physician visits were conducted at least every 60 days after the first 90 days of admission for three of 61 residents reviewed (Residents 8, 13, 61).</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 8, dated September 17, 2024, revealed that the resident was cognitively impaired, was understood and able to understand others, required assistance with care needs, and had diagnoses that included dementia with behaviors and chronic obstructive pulmonary disease (COPD) (chronic lung disease making breathing difficult).</p> <p>A physician's note, dated February 5, 2024, indicated that Resident 8 disenrolled from Senior Life Services and transferred physicians effective February 1, 2024.</p> <p>Clinical record reviews for Resident 8 revealed that the resident was seen by the physician on February 26, 2024, and July 29, 2024. There is no documented evidence that Resident 8 was seen by a physician or physician delegate for 155 days between February 26, 2024, and July 29, 2024.</p> <p>A quarterly MDS assessment for Resident 13, dated August 23, 2024, indicated that the resident was cognitively intact, required assistance from staff for care needs, had an indwelling catheter (a thin, flexible tube inserted into the bladder to drain urine from the bladder), received dialysis (treatment to remove extra fluid and waste from the blood when the kidneys are not able to), and had diagnoses that included neurogenic dysfunction of the bladder (bladder lacks control due to nerve or muscle problems) and End-Stage Renal Disease (kidneys no longer work as they should to meet the body's needs requiring dialysis or kidney transplant).</p> <p>Clinical record reviews for Resident 13 revealed that the resident was seen by the physician on October 26, 2023; February 29, 2024; and July 29, 2024. There was no documented evidence that Resident 13 was seen by a physician or physician delegate for 116 days between October 26, 2023, and February 29, 2024, or for 155 days between February 29, 2024, and July 29, 2024.</p> <p>An annual MDS assessment for Resident 61, dated September 19, 2024, revealed that the resident was cognitively intact, was understood and able to understand others, required minimal assistance with care needs, and had diagnoses that included dementia, Wernicke's encephalopathy (a degenerative brain disorder caused by a lack of vitamin B1), bipolar disorder (mood disorder), and depression.</p> <p>Clinical record reviews for Resident 61 revealed that the resident was seen by the physician on October 6, 2023; February 28, 2024; and July 24, 2024. There was no documented evidence that Resident 61 was seen by a physician or physician delegate for 144 days between October 6, 2023, and February 28, 2024, or for 148 days between February 28, 2024, and July 24, 2024.</p> <p>(continued on next page)</p>		

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<p>F 0712</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview with the Director of Nursing on October 8, 2024, at 10:15 a.m. confirmed that there was no documented evidence that Residents 8, 13, and 61 were seen by a physician or physician delegate at least every 60 days between the above-mentioned dates. She indicated that Resident 8's, 13's and 61's physician does not have a physician's assistant or certified registered nurse practitioner who works with her to oversee these resident's care.</p> <p>28 Pa. Code 211.2(a) Physician Services.</p>		

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<p>F 0730</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observe each nurse aide's job performance and give regular training.</p> <p>19102</p> <p>Based on review of facility policies and personnel files, as well as staff interviews, it was determined that the facility failed to ensure that nurse aide performance evaluations were completed annually based on hire dates for two of three nurse aides reviewed (Nurse Aides 8, 9).</p> <p>Findings include:</p> <p>The facility's policy regarding performance evaluations, dated July 19, 2024, indicated that performance evaluations were to be completed annually and thereafter.</p> <p>A list of nurse aides provided by the facility revealed that based on their months and days of hire, annual performance evaluations were due between April 8 and July 1, 2024, for Nurse Aide 8 and Nurse Aide 9. However, there was no documented evidence that annual performance evaluations were completed as required for these nurse aides.</p> <p>Interview with the Director of Nursing on October 8, 2024, at 2:30 p.m. confirmed that the annual performance evaluations were not completed as required for Nurse Aides 8 and 9.</p> <p>28 Pa. Code 201.18(e)(1) Management.</p>

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>48941</p> <p>Based on review of clinical records, as well as staff interviews, it was determined that the facility failed to ensure that the physician responded timely to pharmacy recommendations for one of 61 residents reviewed (Resident 61).</p> <p>Findings include:</p> <p>An annual Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 61, dated September 19, 2024, revealed that the resident was cognitively intact, was understood and able to understand others, required minimal assistance with care needs, was taking an antipsychotic medication (medications used to treat mental health disorders), and had diagnoses that included dementia, Wernicke's encephalopathy (a degenerative brain disorder caused by a lack of vitamin B1), bipolar disorder (mood disorder), and depression.</p> <p>Physician's orders for Resident 61, dated October 6, 2023, included an order for the resident to receive 0.5 mg of Risperidone (antipsychotic medication) twice daily for bipolar disorder.</p> <p>Physician's orders for Resident 61, dated October 5, 2023, included an order for the resident to receive 50 milligrams (mg) of Sertraline (antidepressant medication) daily.</p> <p>A monthly pharmacy medication regimen review for Resident 61, dated March 14, 2024, revealed a recommendation for a gradual dose reduction of Risperidone and Sertraline. There was no documented evidence that the pharmacy recommendation was addressed or a gradual dose reduction attempted.</p> <p>A monthly pharmacy medication regimen review for Resident 61, dated June 18, 2024, revealed a recommendation for a gradual dose reduction of Risperidone and Sertraline. There was no documented evidence that the pharmacy recommendation was addressed or a gradual dose reduction attempted.</p> <p>Interview with the Director of Nursing on October 8, 2024, at 10:15 a.m. confirmed that there was no documented evidence that the pharmacy recommendations were addressed or a gradual dose reduction attempted for Resident 61 on the above-mentioned dates.</p> <p>28 Pa. Code 211.12(d)(3)(5) Nursing Services.</p>		

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NAME OF PROVIDER OR SUPPLIER  Twin Lakes Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  227 Sand Hill Road Greensburg, PA 15601	
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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46994</p> <p>Based on review of facility policies, observations, and staff interviews, it was determined that the facility failed to provide a separately-locked, permanently-affixed compartment in the refrigerator for the storage of controlled drugs in one of two medication rooms reviewed (medication room on [NAME] unit), failed to discard an expired multi-dose inhaler in one of three carts reviewed ([NAME] long hall cart), failed to label an opened, multi-dose insulin vial in one of three carts reviewed ([NAME] long hall cart), and failed to ensure that medications were properly stored and labeled for two of 61 residents reviewed (Residents 78, 108).</p> <p>Findings include:</p> <p>The facility's policy regarding medication labeling and storage, dated [DATE], indicated that controlled substances (medications with the potential to be abused) and other drugs subject to abuse are separately locked in permanently-affixed compartments. Multi-dose vials that have been opened or accessed (e.g., needle punctured) are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial. Each resident's medications are assigned to an individual cubicle, drawer, or other holding area to prevent the possibility of mixing medications of several residents. Medications and biologicals are stored in packaging, containers, or other dispensing systems in which they are received. Nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary method.</p> <p>Observations in the facility's medication room refrigerator on [NAME] unit on [DATE], at 11:28 a.m. revealed two locked compartments in the refrigerator. There was an empty, locked compartment affixed to a shelf in the refrigerator that was secured behind two bolts and not able to be removed from the refrigerator. The other locked compartment in the refrigerator was locked and secured to a shelf that was able to be removed from the refrigerator. This unsecured, locked compartment contained one opened bottle of liquid Ativan (a medication used to treat anxiety that is tightly controlled because it may be abused or cause addiction), three boxes of unopened liquid Ativan listed as Omnicell stock, and a bag with two small unopened vials of Ativan listed as Omnicell stock.</p> <p>Manufacturer's directions for use of Fluticasone-Salmeterol (Wixela) (an inhaled medication used to help open the airways and make it easier to breathe), dated [DATE], indicated to discard Fluticasone-Salmeterol one month after opening the foil pouch or when the counter reads 0, whichever comes first.</p> <p>Physician's orders for Resident 14, dated [DATE], included an order for the resident to inhale one puff of Fluticasone-Salmeterol Inhalation Aerosol Powder ,d+[DATE] micrograms (mcg) twice daily for asthma (inflammatory disease of the airways making it difficult to breathe). Observations of the long cart on [NAME] unit on [DATE], at 11:01 a.m. revealed an opened container of Resident 14's Fluticasone-Salmeterol that was dated as opened on [DATE], and the use-by date was dated as [DATE]. The instructions on the medication container indicated to discard the medication 30 days after removing it from the foil pouch.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with Licensed Practical Nurse 10 on [DATE], at 11:01 a.m. confirmed that the opened container of Resident 14's Fluticasone-Salmeterol was beyond the use-by date and should have been discarded and it was not.</p> <p>Manufacturer's directions for Lantus (Glargine) insulin (injectable medication to lower blood sugar levels), dated [DATE], revealed that vials of Lantus should be thrown away after 28 days, even if there is insulin left in it.</p> <p>Physician's orders for Resident 15, dated [DATE], included an order for the resident to receive 15 units of Glargine insulin subcutaneously (injection of medication into the fatty layer between the skin and muscle) at bedtime for diabetes. Observations of the long cart on [NAME] unit on [DATE], at 11:01 a.m. revealed that a multi-use vial of Lantus insulin for Resident 15 was opened and was not labeled with the date it was opened.</p> <p>Interview with Licensed Practical Nurse 10 at the time of observation confirmed that the Lantus insulin for Resident 15 should have been labeled with the date it was opened and it was not.</p> <p>Interview with the Director of Nursing on [DATE], at 1:25 p.m. confirmed that the shelf with the locked compartment containing the controlled medications in the refrigerator on [NAME] unit should have been permanently affixed to the refrigerator, confirmed that Resident 14's Fluticasone-Salmeterol inhaler should have been discarded and it was not, and confirmed that Resident 15's vial of Lantus insulin should have been dated and it was not.</p> <p>A quarterly Minimum Data Set (MDS) for Resident 78, dated [DATE], indicated that the resident was cognitively intact, was dependent on staff for daily care needs, and had diagnosis that included hemiplegia (muscle weakness or partial paralysis on one side of the body) following a stroke (disruption in blood flow to the brain) affecting the right side.</p> <p>Observation of Resident 78 on [DATE], at 11:50 a.m. revealed that the resident was lying in his bed in his room. An unsupervised medicine cup with two unlabeled pills in it was sitting on his overbed table. An interview with Resident 78 at that time revealed that he did not know the pills were on his table and that nurses will frequently leave his pills sitting there if he is sleeping when the nurse comes into his room to administer his medication.</p> <p>An interview with Licensed Practical Nurse 2 on [DATE], at 11:54 a.m. revealed that she did leave medication in Resident 78's room because she thought he was awake and was going to take them. She did not stay in the room to observe the resident take the medication.</p> <p>A quarterly MDS for Resident 108, dated [DATE], indicated that the resident was usually understood and could usually understand others, required assistance from staff for daily care needs, and had diagnosis that included bipolar disorder (mental health condition that causes extreme mood swings) and presence of surgical wounds.</p> <p>Observation of Resident 108 on [DATE], at 10:45 a.m. revealed the resident was lying in bed and an unsupervised medicine cup containing nine unlabeled clean and dry pills was sitting on her overbed table. Interview with Resident 108 at that time revealed that they were her morning medications that were left with her to take, but she had not taken them yet.</p> <p>(continued on next page)</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with Licensed Practical Nurse 3 on [DATE], at 10:48 a.m. revealed that she gave Resident 108 her medication and she thought the resident had taken them; however, she was not observed swallowing the medication and must have spit them back out.</p> <p>An interview with the Director of Nursing on [DATE], at 2:31 p.m. confirmed that medications should not have been left unsupervised and unlabeled at the bedside for Resident 78 and Resident 108.</p> <p>28 Pa. Code 211.9(a)(1) Pharmacy Services.</p> <p>28 Pa. Code 211.12(d)(1) Nursing Services.</p>

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<p>F 0810</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide special eating equipment and utensils for residents who need them and appropriate assistance.</p> <p>19102</p> <p>Based on review of facility policies and clinical records, as well as observations and staff interviews, it was determined that the facility failed to provide adaptive eating equipment as ordered by the physician for one of 61 residents reviewed (Resident 42).</p> <p>Findings include:</p> <p>The facility's policy for assistance with meals, dated July 19, 2024, indicated that adaptive devices (special eating equipment and utensils) would be provided for residents who needed or requested them.</p> <p>A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 42, dated July 21, 2024, indicated that the resident was cognitively intact and required set-up assistance from staff with eating. A therapy screen, dated June 20, 2024, revealed that the resident requested adaptive silverware due to arthritis in his hands. He complained of cramping in his hands after completing wheelchair mobility that affected his ability to hold standard utensils. He demonstrated independence with the use of built-up utensils (utensils with foam handles) and was pleased with the equipment. A care plan, dated June 20, 2024, indicated that he was to utilize built-up utensils.</p> <p>Physician's orders for Resident 42, dated September 19, 2024, included an order for built-up utensils.</p> <p>Observations of Resident 42 during the lunch meal on October 8, 2024, at 12:54 p.m. revealed that the resident was in his room eating his meal with regular utensils and did not have built-up utensils. The resident's meal ticket did not include built-up utensils.</p> <p>Interview with Nurse Aide 11 on October 8, 2024, at 12:56 a.m. confirmed that Resident 42 did not have built-up utensils and should have them.</p> <p>Interview with the Director of Nursing on October 8, 2024, at 1:50 p.m. confirmed that Resident 42 should have had built-up utensils if they were ordered and care planned.</p> <p>28 Pa. Code 211.12(d)(3)(5) Nursing Services.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>31760</p> <p>Based on review of clinical records, as well as staff interviews, it was determined that the facility failed to ensure that clinical records were complete and accurately documented for one of 61 residents reviewed (Resident 130).</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 130, dated August 6, 2024, revealed that the resident was understood, could understand others, and had a diagnosis which included chronic obstructive pulmonary disease (COPD - a common lung disease that makes it difficult to breathe) and gastroesophageal reflux disease (GERD - a chronic condition that occurs when stomach contents leak into the esophagus, causing irritation and other symptoms). A care plan for the resident, dated May 20, 2024, revealed that the resident had an actual/potential for weight loss/gain and staff was to provide diet/supplements per orders.</p> <p>Physician's orders for Resident 130, dated May 14, 2024, included an order for the resident to receive regular texture, thin consistency, regular diet.</p> <p>Review of nurse aide documentation for Resident 130, dated June, July, and August 2024, revealed that staff was to document the amount that the resident ate for each meal. However, on June 2, 8, and 14, 2024, at 9:00 a.m.; on June 2, 8, and 14, 2024, at 1:00 p.m.; on June 9, 15, and 24, 2024, at 6:00 p.m.; on July 6, 7, and 24, 2024, at 9:00 a.m.; on July 6, 7, and 24, 2024, at 1:00 p.m.; and on August 12, 2024, at 1:00 p.m. there was no documented evidence regarding the amount that the resident ate during the meals on the above dates.</p> <p>Interview with the Director of Nursing on October 9, 2024, at 9:32 a.m. confirmed that there was no documented evidence in Resident 130's clinical record of how much the resident ate during the meals on the above dates.</p> <p>28 Pa. Code 211.5(f) Clinical Records.</p>		

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.</p> <p>46994</p> <p>Based on review of the facility's plans of correction for previous surveys, and the results of the current survey, it was determined that the facility's Quality Assurance Performance Improvement (QAPI) committee failed to correct quality deficiencies and ensure that plans to improve the delivery of care and services effectively addressed recurring deficiencies.</p> <p>Findings include:</p> <p>The facility's deficiencies and plans of corrections for a State Survey and Certification (Department of Health) survey ending November 9, 2023, and complaint investigation surveys ending March 5, 2024, and May 30, 2024, revealed that the facility developed plans of correction that included quality assurance systems to ensure that the facility-maintained compliance with cited nursing home regulations. The results of the current survey, ending October 9, 2024, identified repeated deficiencies related to accuracy of Minimum Data Sets (MDS), creating and implementing care plans, revision of care plans, quality of care, and tube feeding management.</p> <p>The facility's plan of correction for a deficiency regarding the accuracy of assessment, cited during the survey ending November 9, 2023, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F641, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure ongoing compliance with regulations regarding accuracy of assessments.</p> <p>The facility's plan of correction for a deficiency regarding developing comprehensive care plans, cited during the survey ending November 9, 2023, revealed that the facility developed a plan of correction that included completing audits and reporting the results of the audits to the QAPI committee for review. The results of the current survey, cited under F656, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure ongoing compliance with regulations regarding the development of comprehensive care plans.</p> <p>The facility's plan of correction for a deficiency regarding a failure to update residents' care plans, cited during the survey ending November 9, 2023, revealed that the facility developed a plan of correction that included completing audits and reporting the results of the audits to the QAPI committee for review. The results of the current survey, cited under F657, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure ongoing compliance with regulations regarding updating residents' care plans.</p> <p>The facility's plan of correction for a deficiency regarding quality care, cited during the surveys ending November 9, 2023; March 5, 2024; and May 30, 2024, revealed that the facility would complete audits and report the results of the audits to the QAPI committee for review. The results of the current survey, cited under F684, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure ongoing compliance with regulations regarding quality care.</p> <p>(continued on next page)</p>		

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility's plans of correction for deficiencies regarding failure to provide proper tube feeding management, cited during the surveys ending November 9, 2023, revealed that the facility developed plans of correction that included completing audits and reporting the results of the audits to the QAPI committee for review. The results of the current survey, cited under F693, revealed that the facility's QAPI committee failed to maintain compliance with the regulation regarding proper tube feeding management.</p> <p>Refer to F641, F656, F657, F684, F693.</p> <p>28 Pa. Code 201.14(a) Responsibility of Licensee.</p> <p>28 Pa. Code 201.18(e)(1) Management.</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>31760</p> <p>Based on manufacturer's directions for use and observations, as well as staff interviews, it was determined that the facility failed to maintain two of three laundry dryers in safe operating condition.</p> <p>Findings include:</p> <p>Manufacturer's directions for use for the tumble dryer, dated February 2022, indicated to keep the area around the exhaust opening and adjacent surrounding area free from the accumulation of lint, dust, and dirt. The interior of the tumble dryer and exhaust duct should be cleaned periodically by qualified service personnel.</p> <p>Observations in the laundry department on October 8, 2024, at 8:44 a.m. revealed that in the compartment above the dryer drum where the gas line entered the back of the dryer towards the room with the washers and the middle dryer had an accumulation of lint. Interview with the Director of Environmental Services at the time of observation confirmed that there was an accumulation of lint.</p> <p>Interview with the Director of Maintenance on October 8, 2024, at 9:00 a.m. confirmed that there was an accumulation of lint in the compartment above the dryer drum where the gas line entered the back of the dryer towards the room with the washers and the middle dryer. He indicated that he had last cleaned the dryers on September 9, 2024.</p> <p>28 Pa. Code 207.2(a) Administrator's Responsibility.</p>