

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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 11/20/2025
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)		
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. Based on clinical record reviews, as well as observations and staff interviews, it was determined that the facility failed to clarify questionable physician's orders for one of 46 residents reviewed (Resident 67). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 67, dated September 30, 2025, revealed that the resident was cognitively intact, was scheduled routine pain medications, had complaints of difficulty or pain when swallowing, had a feeding tube (a mechanical device surgically implanted into the stomach to provide nutrition, fluids and medications to a person who is unable or has difficulty eating or drinking by mouth) and received tube feedings, was on a mechanically altered diet, received opioid medications (a controlled pain medication), had a tracheostomy (surgical incision in the neck that creates an opening into the windpipe), and had diagnoses including chronic respiratory failure (blood does not have enough oxygen and causes difficulty breathing), malignant neoplasm of the oropharynx (throat cancer), acquired absence of the larynx (connects the throat to the windpipe and plays a role in swallowing, breathing and speech). Physician's orders for Resident 67, dated October 1, 2025, included an order to give 100 milligrams (mg) of Trazadone (an antidepressant medication used to treat depression or aide with sleep) by mouth at bedtime. Physician's orders for Resident 67, dated October 6, 2025, included an order for the resident to receive 5 mg of Oxycodone (a controlled pain medication) by mouth every 24 hours as needed for breakthrough pain. Physician's orders for Resident 67, dated October 13, 2025, included an order to give 600 mg of Gabapentin (medication used to treat pain) by mouth three times a day for pain scheduled to be given at 9:00 a.m., 2:00 p.m. and 8:00 p.m. Physician's orders for Resident 67, dated November 19, 2025, included an order to give 500 mg of Cephalexin (an antibiotic) by mouth two times a day for five days. Observations of Resident 67 on November 18, 2025, at 9:40 a.m. revealed the resident sitting at the edge of his bed. Licensed Practical Nurse 2 came into the resident's room and administered his 9:00 a.m. medications through his feeding tube. There was no documented evidence in Resident 67's clinical record to indicate that the facility attempted to clarify the physician's orders for the medications listed above to indicate if the medications should be given through his feeding tube or by mouth. Interview with the Director of Nursing on November 20, 2025, at 8:38 a.m. revealed that Resident 67 takes some of his medications by mouth and some by way of his feeding tube per his preference. Interview with Resident 67 on November 20, 2025, at 10:13 a.m. revealed that he does not take any of his medications by mouth. He indicated that all of his medications are crushed and administered by way of his feeding tube because he cannot swallow. Interview with Licensed Practical Nurse 3 on November 20, 2025, at 10:14 a.m. confirmed that Resident 67 does not take any medications by mouth. She indicated that all of his medications were crushed and given by way of his feeding tube. She indicated that his Gabapentin had been recently changed to the 600 mg tablet that could be crushed. Interview with the Director of Nursing on November 20, 2025, at 10:37 a.m. confirmed that the physician's orders for Resident 67's medications listed above, should have been clarified to indicate if the medications should have been given through his feeding tube or by mouth, and they were not. 28 Pa. Code 211.12(d)(1) Nursing Services.		

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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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observations and resident and staff interviews, it was determined that the facility failed to serve food that was palatable to residents. Findings include: Interview with Resident 1 on November 17, 2025, at 1:33 p.m. revealed that he did not like the food because the meat and potatoes were always over cooked and tough to chew. Interview with Resident 94 on November 17, 2025, at 1:19 p.m. revealed that the meat was very tough, and at times she could not eat what was served. She said that the meat was usually dry and too tough to cut or chew. Observations in the kitchen on November 20, 2025, at 12:23 p.m. revealed that the lunch meal consisted of Salisbury steak, scalloped potatoes, mixed vegetables, and gelatin. These items were placed on a test tray at 12:30 p.m. and tasted for palatability. The Salisbury steak was covered with gravy, hard and crispy around the edges and tough to cut. Interview with the Dietary Manager on November 20, 2025, at 12:33 p.m. confirmed that the Salisbury steak was harder and crispy on the edges. She indicated that the oven does not heat evenly, and one side is hotter than the other. She believed that is why the edges get hard and indicated that the edges of the food often get done before the middle. 28 Pa. Code 211.6(b) Dietary Services		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on review of facility policies, as well as observations and staff interviews, it was determined that the facility failed to ensure that food was served under sanitary conditions. Findings include: The facility's policy related to sanitation, dated July 28, 2025, revealed that all equipment, food contact surfaces and utensils would be washed to remove or completely loosen soils by using manual or mechanical means necessary, and sanitized using hot water and/or chemical sanitizing solutions. Manual washing and sanitizing would employ a three-step process for washing, rinsing and sanitizing: scrape food particles and wash using hot water and detergent; rinse with hot water to remove soap residue; and sanitize with hot water or chemical sanitizing solution. Observations in the kitchen on November 17, 2025, at 9:08 a.m. revealed that the three-compartment sink was being used and there were utensils and pans drying on the counter; however, the sanitizer log, dated November 2025, revealed that there was no documented evidence that temperature/chemical checks were being done for each meal from November 11, 2025 through breakfast on November 17, 2025. Interview with the Dietary Manager on November 17, 2025, at the time of the observation, confirmed that there was no documented evidence that temperature/chemical checks were being done for each meal from November 11, 2025, through breakfast on November 17, 2025. 28 Pa. Code 211.6(f) Dietary Services.		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 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 bell was within reach for one of 46 residents reviewed (Resident 85). Findings include: Review of the facility's call bell policy, dated July 28, 2025, indicated that the call light was to be accessible to the resident when in bed. An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's care needs and abilities) for Resident 85, dated October 31, 2025, revealed that the resident could make herself understood and understand others, required assistance from staff for care needs, was incontinent of bowel and bladder, and had diagnoses that included seizures and stroke. A care plan for Resident 85, dated October 26, 2025, indicated that the resident was at risk for falls due to impaired mobility, and the call bell was to be in reach. Observations of Resident 85 on November 17, 2025, at 11:10 a.m. revealed that the resident was laying on her bed requesting pain medication. Her call bell was positioned on the top of the bed, above her and out of reach. When she was asked where her call bell was, she indicated that she did not know. Interview with Registered Nurse Supervisor 1 on November 17, 2025, at 11:16 a.m., confirmed that the tap call bell should have been over her lap so that she could reach it. Interview with the Director of Nursing on November 18, 2025, at 10:12 a.m. confirmed that Resident 85's call bell should have been within reach. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing Services.		

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 ensure that comprehensive admission Minimum Data Set assessments were completed in the required time frame for five of 48 residents reviewed (Residents 46, 68, 71, 83, 122). Findings include: The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which provides instructions and guidelines for completing required Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated October 2024, indicated that an admission MDS assessment was to be completed no later than 14 days (admission date + 13 calendar days) following admission. An admission MDS assessment for Resident 46 revealed that the resident was admitted to the facility on [DATE], and the resident's admission MDS assessment was dated as completed on October 28, 2025, which was 14 days after admission. An admission MDS assessment for Resident 68 revealed that the resident was admitted to the facility on [DATE], and the resident's admission MDS assessment was dated as completed on October 28, 2025, which was 22 days after admission. An admission MDS assessment for Resident 71 revealed that the resident was admitted to the facility on [DATE], and the resident's admission MDS assessment was dated as completed on October 28, 2025, which was 14 days after admission. An admission MDS assessment for Resident 83 revealed that the resident was admitted to the facility on [DATE], and the resident's admission MDS assessment was dated as completed on October 28, 2025, which was 14 days after admission. An admission MDS assessment for Resident 122 revealed that the resident was admitted to the facility on [DATE], and the resident's admission MDS assessment was dated as completed on October 28, 2025, which was 15 days after admission. Interview with the Director of Nursing on November 20, 2025, at 1:48 p.m. confirmed that the above comprehensive MDS assessments were not completed in the required time frames. 28 Pa. Code 211.5(f) Clinical records.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on clinical record reviews, as well as resident and staff interviews, it was determined that the facility failed to implement an individualized care plan for dental needs for one of 46 residents reviewed (Resident 89). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 89, dated September 16, 2025, indicated that the resident was alert and oriented, and required assistance for daily care, including oral care. A physician's order for Resident 89, dated November 2025, revealed that the resident was scheduled for dental extractions in January 2026 and that she required pre-testing for extractions in December 2025. There was no documented evidence that a care plan was developed to address Resident 89's care needs related to her dental problems. An interview with Resident 89 on November 17, 2025, at 11:38 a.m. revealed that the resident had multiple teeth missing, had obvious dental carries, as well as misaligned front teeth. She indicated that she was in need of dental care to pull several teeth. An interview with the Director of Nursing on November 19, 2025, at 11:12 a.m. revealed that there was no care plan in place regarding Resident 89's dental needs and that there should have been. 28 Pa. Code 211.10 (a)(c)(d) Resident care policies 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on review of clinical records, as well as observations and resident and staff interviews, it was determined that the facility failed to ensure that care plans were updated to reflect changes in care needs for one of 46 residents reviewed (Resident 7). Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 7, dated October 31, 2025, revealed that the resident was cognitively impaired, was dependent on staff for daily care needs and had diagnoses that included anxiety, dementia and psychosis (a mental state involving a loss with reality with symptoms of delusions and hallucinations). Physician's orders, dated April 25, 2025, included an order to discontinue Resident 7's quetiapine (an antipsychotic medication). A care plan for Resident 7, dated June 12, 2025, indicated that the resident was at risk for adverse effects related to the use of antipsychotic medication. Interview with the Director of Nursing on November 19, 2025, at 1:25 p.m. confirmed that Resident 7's care plan should have been revised when her quetiapine was discontinued, and it was not. 28 Pa. Code 211.11(d) Resident care plan. 28 Pa. Code 211.12(d)(5) Nursing services.		

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. Based on review of policies and clinical records, as well as observations and staff interviews, it was determined that the facility failed to ensure that foot care needs were provided timely for one of 46 residents reviewed (Resident 6). Findings include: The facility's policy regarding podiatry services (specialized foot care), dated July 28, 2025, indicated that the residents were to receive the appropriate care and treatment in order to maintain mobility and foot health. Overall foot care included the care and treatment of medical conditions to prevent foot complications from these conditions (e.g., diabetes, peripheral vascular disease, immobility, etc.). An annual Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 6, dated September 18, 2025, indicated that the resident was alert and oriented, dependent on staff for daily care needs, and had a diagnosis of diabetes (disease that interferes with blood sugar control). A podiatry note, dated May 16, 2025, revealed that Resident 6 was seen for routine podiatry care and his chief complaint was onychomycosis (a fungal infection of the nail causing them to become discolored, thick and brittle). A recommendation was made for Resident 6 to have routine podiatry care again in 12 weeks and he was placed on the podiatry list to be seen on September 12, 2025. Observations on November 17, 2025, at 10:45 a.m. revealed that all of Resident 6's toenails were mycotic and approximately one-quarter inch over the ends of his toes, and both great toes were wrapped with a dry dressing. There was no documented evidence that Resident 6 received podiatry care on September 12, 2025. Interview with the Director of Nursing on November 19, 2025, at 12:06 p.m. confirmed that Resident 6 should have received podiatry care when the podiatrist visited the facility on September 12, 2025, and he did not. 28 Pa. Code 211.12(d)(3)(5) Nursing services.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of policies, investigation reports, clinical records, and staff education records, as well as staff interviews, it was determined that the facility failed to ensure that residents were free from accidents that resulted in injury for one of 46 residents reviewed (Resident 46). This deficiency is being cited as past non-compliance. Findings include: The facility's Assistive Devices and Equipment policy, dated July 28, 2025, indicated that residents who did not self-propel, should have leg rests on their wheelchair when being transported. admission paperwork for Resident 46, dated October 14, 2025, revealed that the resident was admitted to the facility on [DATE], from the hospital with a diagnosis of Covid pneumonia, stasis dermatitis of bilateral lower extremities, and also had a history of trans ischemic attack (mini-stroke). Resident on two liters of oxygen via nasal cannula. She was alert and oriented and required assistance from two staff members for care. Resident 46 utilized a walker or a wheelchair for mobility. An incident note for Resident 46, dated November 10, 2025, revealed that the resident was being transported back to the resident's room in her wheelchair by an activity aide. She then dropped her feet onto the floor with the wheelchair in motion and fell forward out of the wheelchair onto floor. She had bleeding from her nose and upper lip. Interview with Resident 46 on November 17, 2025, at 1 p.m. stated that the footrests were not in place on her wheelchair at the time of the fall. A written statement by the activity aide, dated November 10, 2025, revealed that Resident 46 was in the dining room for Bingo and stated that she needed to go to the bathroom. She pushed the resident back to her room; she put feet on the floor and fell out of the wheelchair. An interview with the Director of Nursing on November 19, 2025, at 10:10 a.m. confirmed that Resident 46 did not have her leg rests on her wheelchair during transport, and that she should have been transported with her leg rests on the wheelchair. Following the incident on November 10, 2025, the facility's corrective actions included: 1. On November 10, 2025, the resident was immediately assessed, and x-ray and neurological checks were initiated per facility protocol. Care was provided to the resident for a minor nasal abrasion. The Activity Aide was immediately suspended pending the investigation and was re-educated on proper wheelchair transport procedures prior to her return to duties. 2. On November 10, 2025, facility wide audit conducted of all wheelchairs to ensure that each had properly attached and functional leg rests and footrests. Ad-hoc Quality Assurance Performance Improvement (QAPI) meeting held on November 11, 2025, to review the incident, identify root causes, and develop corrective and preventative measures. 3. Education records, dated November 12, 2025, revealed that all of the facility's nursing, Activities, Therapy, and Support department staff received re-education regarding proper wheelchair use and transport safety. Ensuring leg rests and footrests are in place before transport and responding safely to residents' toileting requests. Safe transport procedures have been incorporated into the new employee orientation. The Falls Performance Improvement Project (PIP) would continue to track all fall-related incidents, including those involving wheelchair transport, for trend analysis. Any future incidents involving equipment misuse or unsafe transport would be reviewed through the QAPI process for systemic improvement. 4. The Director of Rehabilitation or designee will conduct daily audits for one week and weekly audits for three weeks to observe at least three random resident transports per unit weekly, ensuring compliance with wheelchair safety and transport. Ongoing compliance will be verified through the facility's monthly Quality Assurance Performance Improvement (QAPI) committee. Review of the facility's corrective actions and interviews completed with staff regarding their re-education revealed that they were in compliance with F689 on November 12, 2025. This deficiency was being cited as past non-compliance. 28 Pa. Code 211.10(c)(d) Resident care policies. 28 Pa. Code 211.11(d) Resident care plan. 28 Pa. Code 211.12(d)(1)(5) Nursing services.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on review of facility policies and clinical records, as well as observations and staff interviews, it was determined that the facility failed to maintain accountability for controlled medications (drugs with the potential to be abused) for one of 46 residents reviewed (Resident 67). Findings include: The facility's policy regarding controlled substance disposal, dated July 28, 2025, indicated that when a fentanyl patch was removed from a resident, the patch was to be folded in half with the adhesive attaching to the adhesive, and the patch was placed in inert material, such as cat litter, to render the mixture unusable in the presence of two licensed personnel. The disposal was to be documented per the facility policy. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 67, dated September 30, 2025, revealed that the resident was cognitively intact, was scheduled routine pain medications, had complaints of difficulty or pain when swallowing, had a feeding tube (a mechanical device surgically implanted into the stomach to provide nutrition, fluids and medications to a person who is unable or has difficulty eating or drinking by mouth) and received tube feedings, was on a mechanically altered diet, received opioid medications (a controlled pain medication), had a tracheostomy (surgical incision in the neck that creates an opening into the windpipe), and had diagnoses including chronic respiratory failure (blood does not have enough oxygen and causes difficulty breathing), malignant neoplasm of the oropharynx (throat cancer), acquired absence of the larynx (connects the throat to the windpipe and plays a role in swallowing, breathing and speech). Physician's orders for Resident 67, dated October 3, 7, and 8, 2025, included orders for the resident to receive 25 micrograms (mcg) of Fentanyl transdermal patch (a narcotic pain medication administered through the skin) to be applied every 72 hours for pain and removed per schedule. Physician's orders for Resident 67, dated October 8, and 22, 2025, and November 6 and 12, 2025, included an order for the resident to receive 50 mcg of Fentanyl transdermal patch to be applied every 72 hours for pain and remove per schedule. Observations of Resident 67 on November 18, 2025, at 9:40 a.m. revealed Licensed Practical Nurse 2 came into the resident's room to administer his a.m. medications. She removed the fentanyl patch from the right side of his chest area, rolled the patch up in her glove and discarded it in the resident's waste basket. She then applied the new patch to his left chest area and left the room. The Medication Administration Record (MAR) and a controlled drug count record (tracks each dose of a controlled medication) for Resident 67, dated October and November 2025, revealed that a Fentanyl patch was applied to the resident on October 3, 7, 9, 12, 15, 19, 22, 25, 28, and 31, 2025; and on November 3, 6, 9, 12, 15 and 18, 2025. There was no documented evidence that two staff members witnessed and signed that the old patch was destroyed after removal on these dates. Interview with Licensed Practical Nurse 2 on November 18, 2025, at 10:17 a.m. confirmed that she should not have discarded Resident 67's fentanyl patch in his waste basket. She indicated that she should have discarded it in the sharps container. Interview with the Registered Nurse Supervisor 1 on November 18, 2025, at 1:25 p.m. indicated that narcotics were to be disposed of in the drug buster. Fentanyl patches would be initialed and dated when applied, would have two nurses initial for disposal of the patch, and it would be placed in the drug buster as well. Interviews with the Director of Nursing on November 18, 2025, at 3:25 p.m. and November 20, 2025, at 10:39 a.m. confirmed that the Fentanyl patch for Resident 67 should not have been discarded in the resident's waste basket and should have been disposed of in the drug buster and witnessed by two nurses, and also confirmed that there was no documented evidence that two staff members witnessed and signed that Resident 67's old patches were destroyed after removal on the above-mentioned dates. 28 Pa. Code 211.9(a)(h) Pharmacy services. 28 Pa. Code 211.12(d)(1)(5) Nursing services.		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to provide medications as ordered by the physician, resulting in a significant medication error for one of 46 residents reviewed (Resident 115). Findings include: The facility policy for medication administration, dated July 28, 2025, indicated that medications were to be administered per physician's orders. A comprehensive Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 115, dated October 27, 2025, indicated that the resident was cognitively intact, had diagnoses that included atrial fibrillation (irregular heartbeat), and received anticoagulant (blood thinner) medications. A care plan for Resident 115, dated October 27, 2025, revealed that the resident was to be medicated with an anticoagulant per the physician's orders. Physician's orders for Resident 115, dated November 13, 2025, included orders for the resident to receive 5 milligrams (mg) of Coumadin (blood thinner) every day. A review of Resident 115's Medication Administration Record (MAR), dated November 2025, indicated that on November 13 and November 14 the resident received 5 mg and an additional 2.5 mg Coumadin each night (total of 7.5 mg). A nursing note for Resident 115, dated November 15, 2025, indicated that the resident was bleeding and an International Normalized Ratio (INR- clotting time) blood level was ordered immediately. The resulting INR was 3.2 (elevated) and the physician ordered the Coumadin be held for two nights as a result. Interview with the Assistant Director of Nursing on November 20, 2025, at 2:25 p.m. confirmed that Resident 115 received the incorrect dose of Coumadin on November 13 and 14, 2025, and that a medication error had occurred. 28 Pa. Code 211.12(d)(1)(5) Nursing services.		

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 11/20/2025
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)		
F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 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. Findings include: The facility's deficiencies and plan of corrections for an annual survey ending October 9, 2024, and a complaint survey ending May 14, 2025, 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 November 20, 2025, identified repeated deficiencies related to a failure to accommodate the needs of a resident, failure to develop individualized care plans, failure to revise care plans, and failure to clarify questionable physician's orders. The facility's plan of correction for a deficiency regarding accommodations of need, cited during the survey ending October 9, 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 F558, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure that resident's needs were accommodated. The facility's plan of correction for a deficiency regarding the development of individualized care plans, cited during the survey ending October 9, 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 F656, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure that resident's care plans were developed for their individual needs. The facility's plan of correction for a deficiency regarding revising care plans, cited during the survey ending October 9, 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 F657, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure that resident's care plans were revised. The facility's plan of correction for a deficiency regarding clarifying questionable physician's orders, cited during the survey ending October 9, 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 F658, revealed that the facility's QAPI committee failed to successfully implement their plan to ensure that questionable physician's orders were clarified. Refer to F558, F656, F657, F658.28 Pa. Code 201.14(a) Responsibility of Licensee.28 Pa. Code 201.18(e)(1) Management.		