STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395500	A. Building B. Wing	12/07/2022

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 38012 Based on a review of facility policies, clinical records, and information submitted by the facility, as well as resident and staff interviews, it was determined that the facility failed to promptly take measures necessary to protect residents from verbal and physical abuse after abuse was identified for two of 47 residents reviewed (Residents 71, 73). This failure placed the residents in immediate jeopardy due to the actual verbal and physical abuse that already occurred, as well as the potential for further verbal and physical abuse to occur. Findings include: Review of the facility's abuse policy, dated February 17, 2022, revealed that residents have the right to be free from abuse and neglect. Nursing notes, dated April 7, 2022, revealed that Resident 71 and Resident 73 arrived at the facility around the same time and were placed in the same room together. Resident 71 is the mother of Resident 73. Interview with Family Member 1 on December 6, 2022, at 1:45 p.m. revealed that Resident 73 had no power of attorney or legal guardian. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 71, dated November 12, 2022, indicated that the resident was cognitively intact, required assistance from staff for daily care needs, had behaviors such as physical and verbal aggression towards others, and had diagnoses that included dementia. Resident 71's care plan for verbal and aggressive behaviors towards Resident 73, dated May 24, 2022, indicated that staff would monitor her aggressive behaviors towards him. A quarterly MDS assessment for Resident 73, dated August 11, 2022, indicated that the resident was cognitively intact, required extensive assistance from staff for care, had a feeding tube (a tube surgically placed into the stomach for nutrition), had behaviors such as verbal aggression, and had diagnoses that included cerebral palsy (injury at birth that causes difficulty with movement, muscle tone and posture), dementia with behavioral disturbance (memory loss), and dysphagia (swallowing difficulties). (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An interview with Family Member 1 on December 6, 2022, at 1:45 p.m. revealed that he did not want his mother and brother separated and he felt that they should remain in the same room. He stated that his mother would never hurt his brother. He said that he knew that his mother had dementia, but he did not think that her having dementia would alter her thought process or her ability to deal with stressful situations. He stated that Resident 73 was independent, enjoyed going for walks, was social in his neighborhood, and enjoyed going out to eat at restaurants. In December 2021 Resident 73 got COVID and became very ill. He was intubated and ended up with a feeding tube as well. He said that Resident 73 deteriorated significantly but because of his intellectual disabilities, Resident 73 does not understand what has happened to him or that he is not able to go home or go out to eat or just walk around anymore. A nursing note for Resident 73, dated April 18, 2022, revealed that he had displayed verbal behaviors such as yelling out. A nursing note, dated April 21, 2022, revealed that Resident 73 was yelling out and threatening staff saying that he did not like anyone there and would get them all in serious trouble by saying they did sexual things to him. Staff were unable to calm him as he yelled, and he began to call the staff names. A nursing note for Resident 71, dated April 19, 2022, revealed that she did not want to be moved to another room away from Resident 73 (her son), despite the yelling and arguing between them. A nursing note for Resident 73, dated April 25, 2022, revealed that he was evaluated by speech therapy and determined that he was not safe to eat foods and that he would continue to require the feeding tube. His sister stated that she understood but still wanted him to have food. A nursing note for Resident 73, dated May 1, 2022, revealed that his family requested he be served food regardless of his risk of aspiration (choking on the food). A nursing note, dated May 6, 2022, revealed that Resident 73 was yelling out and Resident 71 began yelling at him, which increased his behaviors. A nursing note for Resident 71, dated May 6, 2022, revealed that she was antagonizing Resident 73 when he was quiet and was heard saying piss your pants, that will get them in trouble. She was very argumentative with caretakers. A nursing note for Resident 73, dated May 6, 2022, revealed that he was yelling out and the nurse heard Resident 71 yell shut up you retard at him. A nursing note for Resident 73, dated May 7, 2022, revealed that he screamed continuously the entire shift and redirection and medication were ineffective. A nursing note for Resident 73, dated May 8, 2022, at 3:58 a.m. revealed that he yelled out the entire shift and was not able to be redirected. Other residents were upset and mad that they could not sleep. A nursing note for Resident 73, dated May 8, 2022, at 10:01 a.m. revealed that he was medicated to calm him, and that Resident 71 was found giving him drinks of water, despite his inability to swallow safely and the physician's order to not give him anything by mouth. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A nursing note, dated May 12, 2022, revealed that Resident 73 and Resident 71 were yelling at each other and that despite the nurse's efforts she could not calm Resident 73. Resident 71 was very agitated and was telling Resident 73 to shut up, shut the hell up, these people hate you and don't want to come in because of you. When asked what she needed, Resident 71 stated him to shut the hell up. She then yelled at Resident 73 I hate you, you're just a waste of time, shut the hell up you idiot. A social service note for Resident 73, dated May 13, 2022, revealed that she phoned his sister to request a family meeting to discuss his behaviors. A social service note for Resident 73, dated May 17, 2022, revealed that a family meeting was held with his siblings. An individual caregiver was recommended to the family, and they were to investigate that suggestion. The family was to update the social worker regarding a one-on-one care intervention. A nursing note for Resident 73, dated May 18, 2022, revealed that the nurse practitioner recommended medication changes and discussed this with his sister. However, on May 19, 2022, his sister decided she did not want any medication changes and wanted the medication discontinued. A nursing note for Resident 73, dated May 21, 2022, revealed that he was very agitated and continually screamed out all shift and was not able to be redirected. He continued to yell out all shift and began to make comments that his mother masturbated him and that he would say staff touched him sexually to get everyone in trouble. He could not be redirected. A nursing note for Resident 73, dated May 24, 2022, revealed that he continuously yelled throughout the shift and that he was not able to be consoled. He yelled at staff and called them names and yelled at Resident 71 as well. A nursing note for Resident 73, dated June 1, 2022, revealed that he continuously yelled out and had attention seeking behaviors. Resident 71 was overheard yelling shut up you retard to Resident 73, which aggravated him more. When the nurse attempted to educate Resident 71 that she should not call him a retard, she replied, I call them like I see them. A nursing note for Resident 71, dated June 16, 2022, revealed that she was having an increase in behaviors and was trying to pull Resident 73 out of bed. She was confused and not easily redirected. Staff phoned her daughter to try to redirect and that was unsuccessful. A nursing note for Resident 73, dated June 23, 2022, revealed that he had increased yelling outbursts at staff and that numerous attempts to calm him were unsuccessful. At 8:15 p.m. the nurse charted that the resident could not be consoled and was continuing to yell and scream so much that he was sweating profusely. He was given one-on-one attention and care and he continued to scream. The family refused medication for behaviors. A nursing note for Resident 71, dated July 4, 2022, revealed that she was complaining of hand and wrist pain and was found to have slight bruising and swelling to the left hand and wrist. The licensed practical nurse stated that she observed Resident 71 slap Resident 73 across the face. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A nursing note for Resident 71, dated July 5, 2022, revealed that the licensed practical nurse now stated she did not see her slap Resident 73, but she heard a slap sound and heard the resident say ouch. A nursing note for Resident 73, dated July 17, 2022, revealed that his family was feeding him food that was not pureed, which was his ordered consistency. A nursing note for Resident 71, dated July 26, 2022, revealed that she was cursing and yelling at staff and yelling at Resident 73 to shut up and called him stupid. A nursing note for Resident 73, dated July 31, 2022, revealed that he was demanding care from staff stating he was wet or soiled; however, when care was provided, he would be dry, and he would yell at the staff and call them swear words. He also continued to yell at his mother. A nursing note for Resident 73, dated August 8, 2022, revealed that he was yelling obscenities and upsetting other residents, unable to be calmed. A nursing note for Resident 73, dated August 11, 2022, revealed that he was found to have cookies that were not pureed and when staff removed them for his safety he yelled and swore loudly and continuously. The speech therapist sat with him and fed him the cookie to try to calm him; however, he continued to yell and scream. A social service's note for Resident 73, dated August 14, 2022, revealed that he was yelling out and Resident 71 called him crazy and told him to shut up. A nursing note for Resident 73, dated August 16, 2022, revealed that he was having behaviors and could not be redirected. Staff phoned his family for assistance, and they stated they would try to come in. A nursing note for Resident 73, dated August 19, 2022, revealed that his sister told nursing staff that she and her siblings had been bringing him regular consistency food in, not pureed, and she would like his diet changed to regular. His sister was educated that he is at risk of aspiration and the family should not bring him in regular foods. A nursing note for Resident 73, dated August 22, 2022, revealed that the nursing staff phoned his sister to inform her that he had medication changes to help with his anxiety and behaviors. A nursing note for Resident 73, dated August 25, 2022, revealed that his sister phoned and again requested his diet be changed to regular because she has been feeding him regular foods. She was informed he would need a test to determine if he was safe on regular foods and she agreed. She was educated that he required pureed foods and nectar thick liquids at that time. A nursing note for Resident 73, dated August 28, 2022, revealed that he returned from a doctor appointment with two cans of regular soda. The soda was placed in the refrigerator for later use. Later that evening the resident fell while screaming they took my pop. A nursing note for Resident 73, dated September 6, 2022, revealed that his sister was observed feeding him a regular can of soda and that she was aware he was not supposed to have it. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A nursing note for Resident 73, dated September 15, 2022, revealed that his sister was in to visit and left him with regular pop in his room. A nursing note for Resident 73, dated October 15, 2022, revealed that he continuously yelled and demanded soda. Staff explained he could not have regular soda and he was angry and stated that his sisters gave him regular soda and so should they. A nursing note for Resident 73, dated October 9, 2022, revealed that he returned from the hospital and was yelling out. His brother phoned the nurses and requested that Resident 73 be medicated with calming medication due to his yelling out and having behaviors. A nursing note for Resident 73, dated October 10, 2022, revealed that his sister did not want him to have calming medications. A nursing note for Resident 73, dated October 17, 2022, revealed that his sister was upset because she believed the facility was over-medicating the resident and that he was sedated. She expressed anger regarding her brother making decisions regarding Resident 73's care. A nursing note for Resident 73, dated October 19, 2022, revealed that he was ordered an anti-emetic (vomiting) medication for calming, to be administered once every eight hours if needed. A nursing note for Resident 73, dated October 26, 2022, revealed that he called staff derogatory names and threatened to put a gun to their head and blow their brains out. A nursing note for Resident 73, dated November 10, 2022, revealed that he was yelling at Resident 71 when she placed her hands on his face and said, Shut up or I will claw your f*cking eyes out. She then pushed his face away. A nursing note for Resident 73, dated November 11, 2022, revealed that his brother did not want Resident 73 moved out of his current room that he shared with Resident 71. He stated that he would talk to his family about having a one-on-one come into the building. Resident 73's sister then phoned and stated she did not want a room move or to have Resident 73 separated from Resident 71. A nursing note for Resident 73, dated November 16, 2022, revealed that his siblings all agreed that Resident 73 could be medicated for his behaviors and that they did not want him separated from Resident 71. A nursing note for Resident 73, dated December 2, 2022, revealed that he had an increase in behaviors and that he and his mother continued to yell at each other, and they could not be redirected. Resident 73's sister was present, and they continued to yell. Despite the ongoing verbal abuse between Resident 73 and Resident 71, as well as nursing notes indicating that they observed physical contact between Resident 71 and Resident 73 when Resident 71 was agitated and frustrated with him, the facility allowed the residents to remain in the same room with each other. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A care plan for Resident 71's verbal and aggressive behaviors towards Resident 73, dated May 24, 2022, indicated that staff would monitor her aggressive behaviors towards him; however, there was no documented evidence that her behaviors were monitored. According to the nursing notes above, staff were unable to redirect Resident 71 or calm her when Resident 73 was yelling out. There was no documented evidence that a care plan addressing Resident 73's behaviors towards his mother was developed until November 6, 2022, seven months after his behaviors began, and it had not been revised to reflect any new interventions since that time. There was no documented evidence that Resident 73's behaviors were being monitored. According to the nursing notes above, staff were never able to redirect him or calm him. During the interview with Family Member 1 on December 6, 2022, at 1:45 p.m., he also stated that he believes Resident 73 yells and screams all the time because he can no longer go home or out to eat or for a walk. He further said that he believes Resident 71 gets upset with Resident 73 because she must listen to him scream all day and all night. Family Member 1 stated that Resident 73 had no power of attorney or legal guardian. Family Member 1 stated that he was the power of attorney for Resident 71, and he thought that gave him the ability to make decisions for Resident 73 as well; however, his siblings were also making decisions for Resident 73, and they would often contradict one another. Family Member 1 stated he thought about getting guardianship for Resident 73, but he was unsure how to go about it and the facility never mentioned that that was an option or that it was important so that one person was making decisions while another family member changed the plan. The facility's failure to act upon the potential signs of physical and verbal abuse placed the residents in immediate jeopardy. The facility indicated that they had interventions in place and that Resident 71's and Resident 73's care plans were updated with interventions to prevent further abuse by either resident; however, a review of the care plans provided revealed that neither resident had any changes regarding their behaviors towards one another. Interview with Nurse Aide 4 on December 5, 2022, at 3:48 p.m. revealed that Residents 71 and 73 often yell at each other and that she tries to separate them; however, they do not like to leave their room. She said that there are family members that visit, but they are not able to get them to stop yelling at each other either. She said the family instigates the residents by bringing food and drink items in for Resident 73 that he cannot have because he is on pureed diet with thickened liquids, then Resident 73 gets angry when staff have to take the items. Then Resident 71 yells at them all. Interview with Nurse Aide 5 on December 5, 2022, at 3:52 p.m. revealed that Resident 71 and Resident 73 constantly yell at each other, and the staff are not able to redirect them. She stated that Resident 73 gets angry that Resident 71 yells at him and then he yells more. She said Resident 71 yells at Resident 73 and calls him names. Interview with Registered Nurse 6 on December 5, 2022, at 4:17 p.m. revealed that Resident 73 yells a lot and that Resident 71 yells and swears at him to shut up and calls him names. She said that recently a nurse aide came to get her because the nurse aide witnessed Resident 71 with her hands on Resident 73's neck telling him to shut up and calling him names. She said she wanted to separate the residents since they room together and constantly yell at one another, but administration told her she is not permitted to move either of them. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An Immediate Jeopardy situation was identified to the Nursing Home Administrator and the Director of Nursing on December 6, 2022, at 12:20 p.m. related to the facility's failure to ensure that immediate and adequate safeguards were taken to protect Resident 73 from potential physical and verbal abuse perpetrated by his mother. Nursing staff observed multiple occasions of verbal abuse by both Resident 71 and 73, as well as Resident 71 getting frustrated and grabbing at or slapping at Resident 73 to get his attention and to tell him to shut up. The corrective action plan included the following interventions: The facility provided one-on-one supervision to monitor Residents 71 and 73 when together until an alternate plan was identified. The facility ordered immediate psychological and psychiatric evaluations for Residents 71 and 73. The facility provided immediate verbal education for staff on implementing abuse prohibition procedures to include: the definition of abuse, identifying abuse, immediate investigation of alleged abuse, reporting of abuse, signs and symptoms of sexual abuse, and protection of residents to prevent the potential for further abuse. Staff will be provided with verbal education on abuse on the beginning of their shift prior to having any contact with residents until all staff have been re-educated. Administrative staff conducted a facility-wide audit 30 days retroactively to identify other residents that were at risk of physical, verbal abuse, and/or psychosocial harm. Administrative staff will perform audits five times a week once a week for two weeks and monthly for two months of any reported/identified altercations between residents indicative of or may lead to abuse of any form. Staff were provided with immediate education on abuse. Following verification of the completion of this corrective action plan the immediate jeopardy was lifted at 3:00 p.m. on December 7, 2022. 42 CFR 483.13 - Resident Behavior and Facility Practices, 10-1-1998 edition. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(e)(1) Management. 28 Pa. Code 201.29(a)(c)(d) Resident rights.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 38012 Based on review of facility policies, clinical records, and investigation documents, as well as staff interviews, it was determined that the facility failed to implement its abuse policy by not immediately protecting residents who were abusive to one another, for two of 47 residents reviewed (Residents 71, 73). Findings include: The facility's policy regarding abuse, dated February 17, 2022, indicated that the facility would thoroughly investigate all reports of suspected or alleged abuse (mental, physical, sexual, involuntary seclusion, or misappropriation of resident property), neglect, or exploitation. If an employee was involved in alleged or suspected abuse, the employee would be immediately removed from duty for the duration of the investigation. The accused employee would be informed that the facility was required to report the allegation and submit a written report to the state upon completion of the investigation. Nursing notes, dated April 7, 2022, revealed that Resident 71 and Resident 73 arrived at the facility around the same time and were placed in the same room together. Resident 71 is the mother of Resident 73. Interview with Family Member 1 on December 6, 2022, at 1:45 p.m. revealed that Resident 73 had no power of attorney or legal guardian. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 71, dated November 12, 2022, indicated that the resident was cognitively intact, required assistance from staff for daily care needs, had behaviors such as physical and verbal aggression towards others, and had diagnoses that included dementia. Resident 71's care plan for verbal and aggressive behaviors towards Resident 73, dated May 24, 2022, indicated that staff would monitor her aggressive behaviors towards him. A quarterly MDS assessment for Resident 73, dated August 11, 2022, indicated that the resident was cognitively intact, required extensive assistance from staff for care, had a feeding tube (a tube surgically placed into the stomach for nutrition), had behaviors such as verbal aggression, and had diagnoses that included cerebral palsy (injury at birth that causes difficulty with movement, muscle tone and posture), dementia with behavioral disturbance (memory loss), and dysphagia (swallowing difficulties). A nursing note for Resident 73, dated April 18, 2022, revealed that he had displayed verbal behaviors such as yelling out. A nursing note, dated April 21, 2022, revealed that Resident 73 was yelling out and threatening staff saying that he did not like anyone there and would get them all in serious trouble by saying they did sexual things to him. Staff were unable to calm him as he yelled, and he began to call the staff names. A nursing note for Resident 71, dated April 19, 2022, revealed that she did not want to be moved to another room away from Resident 73 (her son), despite the yelling and arguing between them. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A nursing note for Resident 73, dated April 25, 2022, revealed that he was evaluated by speech therapy and determined that he was not safe to eat foods and that he would continue to require the feeding tube. His sister stated that she understood but still wanted him to have food. A nursing note for Resident 73, dated May 1, 2022, revealed that his family requested he be served food regardless of his risk of aspiration (choking on the food). A nursing note, dated May 6, 2022, revealed that Resident 73 was yelling out and Resident 71 began yelling at him, which increased his behaviors. A nursing note for Resident 71, dated May 6, 2022, revealed that she was antagonizing Resident 73 when he was quiet and was heard saying piss your pants, that will get them in trouble. She was very argumentative with caretakers. A nursing note for Resident 73, dated May 6, 2022, revealed that he was yelling out and the nurse heard Resident 71 yell shut up you retard at him. A nursing note for Resident 73, dated May 7, 2022, revealed that he screamed continuously the entire shift and redirection and medication were ineffective. A nursing note for Resident 73, dated May 8, 2022, at 3:58 a.m. revealed that he yelled out the entire shift and was not able to be redirected. Other residents were upset and mad that they could not sleep. A nursing note for Resident 73, dated May 8, 2022, at 10:01 a.m. revealed that he was medicated to calm him, and that Resident 71 was found giving him drinks of water, despite his inability to swallow safely and the physician's order to not give him anything by mouth. A nursing note, dated May 12, 2022, revealed that Resident 73 and Resident 71 were yelling at each other and that despite the nurse's efforts she could not calm Resident 73. Resident 71 was very agitated and was telling Resident 73 to shut up, shut the hell up, these people hate you and don't want to come in because of you. When asked what she needed, Resident 71 stated him to shut the hell up. She then yelled at Resident 73 I hate you, you're just a waste of time, shut the hell up you idiot. A social service note for Resident 73, dated May 13, 2022, revealed that she phoned his sister to request a family meeting to discuss his behaviors. A social service note for Resident 73, dated May 17, 2022, revealed that a family meeting was held with his siblings. An individual caregiver was recommended to the family, and they were to investigate that suggestion. The family was to update the social worker regarding a one-on-one care intervention. A nursing note for Resident 73, dated May 18, 2022, revealed that the nurse practitioner recommended medication changes and discussed this with his sister. However, on May 19, 2022, his sister decided she did not want any medication changes and wanted the medication discontinued. A nursing note for Resident 73, dated May 21, 2022, revealed that he was very agitated and continually screamed out all shift and was not able to be redirected. He continued to yell out all shift and began to make comments that his mother masturbated him and that he would say staff touched him sexually to get everyone in trouble. He could not be redirected. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A nursing note for Resident 73, dated May 24, 2022, revealed that he continuously yelled throughout the shift and that he was not able to be consoled. He yelled at staff and called them names and yelled at Resident 71 as well. A nursing note for Resident 73, dated June 1, 2022, revealed that he continuously yelled out and had attention seeking behaviors. Resident 71 was overheard yelling shut up you retard to Resident 73, which aggravated him more. When the nurse attempted to educate Resident 71 that she should not call him a retard, she replied, I call them like I see them. A nursing note for Resident 71, dated June 16, 2022, revealed that she was having an increase in behaviors and was trying to pull Resident 73 out of bed. She was confused and not easily redirected. Staff phoned her daughter to try to redirect and that was unsuccessful. A nursing note for Resident 73, dated June 23, 2022, revealed that he had increased yelling outbursts at staff and that numerous attempts to calm him were unsuccessful. At 8:15 p.m. the nurse charted that the resident could not be consoled and was continuing to yell and scream so much that he was sweating profusely. He was given one-on-one attention and care and he continued to scream. The family refused medication for behaviors. A nursing note for Resident 71, dated July 4, 2022, revealed that she was complaining of hand and wrist pain and was found to have slight bruising and swelling to the left hand and wrist. The licensed practical nurse stated that she observed Resident 71 slap Resident 73 across the face. A nursing note for Resident 71, dated July 5, 2022, revealed that the licensed practical nurse now stated she did not see her slap Resident 73, but she heard a slap sound and heard the resident say ouch. A nursing note for Resident 73, dated July 17, 2022, revealed that his family was feeding him food that was not pureed, which was his ordered consistency. A nursing note for Resident 71, dated July 26, 2022, revealed that she was cursing and yelling at staff and yelling at Resident 73 to shut up and called him stupid. A nursing note for Resident 73, dated July 31, 2022, revealed that he was demanding care from staff stating he was wet or soiled; however, when care was provided, he would be dry, and he would yell at the staff and call them swear words. He also continued to yell at his mother. A nursing note for Resident 73, dated August 8, 2022, revealed that he was yelling obscenities and upsetting other residents, unable to be calmed. A nursing note for Resident 73, dated August 11, 2022, revealed that he was found to have cookies that were not pureed and when staff removed them for his safety he yelled and swore loudly and continuously. The speech therapist sat with him and fed him the cookie to try to calm him; however, he continued to yell and scream. A social service's note for Resident 73, dated August 14, 2022, revealed that he was yelling out and Resident 71 called him crazy and told him to shut up. (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A nursing note for Resident 73, dated August 16, 2022, revealed that he was having behaviors and could not be redirected. Staff phoned his family for assistance, and they stated they would try to come in. A nursing note for Resident 73, dated August 19, 2022, revealed that his sister told nursing staff that she and her siblings had been bringing him regular consistency food in, not pureed, and she would like his diet changed to regular. His sister was educated that he is at risk of aspiration and the family should not bring him in regular foods. A nursing note for Resident 73, dated August 22, 2022, revealed that the nursing staff phoned his sister to inform her that he had medication changes to help with his anxiety and behaviors. A nursing note for Resident 73, dated August 25, 2022, revealed that his sister phoned and again requested his diet be changed to regular because she has been feeding him regular foods. She was informed he would need a test to determine if he was safe on regular foods and she agreed. She was educated that he required pureed foods and nectar thick liquids at that time. A nursing note for Resident 73, dated August 28, 2022, revealed that he returned from a doctor appointment with two cans of regular soda. The soda was placed in the refrigerator for later use. Later that evening the resident fell while screaming they took my pop. A nursing note for Resident 73, dated September 6, 2022, revealed that his sister was observed feeding him a regular can of soda and that she was aware he was not supposed to have it. A nursing note for Resident 73, dated September 15, 2022, revealed that his sister was in to visit and left him with regular pop in his room. A nursing note for Resident 73, dated October 15, 2022, revealed that he continuously yelled and demanded soda. Staff explained he could not have regular soda and he was angry and stated that his sisters gave him regular soda and so should they. A nursing note for Resident 73, dated October 9, 2022, revealed that he returned from the hospital and was yelling out. His brother phoned the nurses and requested that Resident 73 be medicated with calming medication due to his yelling out and having behaviors. A nursing note for Resident 73, dated October 10, 2022, revealed that his sister did not want him to have calming medications. A nursing note for Resident 73, dated October 17, 2022, revealed that his sister was upset because she believed the facility was over-medicating the resident and that he was sedated. She expressed anger regarding her brother making decisions regarding Resident 73's care. A nursing note for Resident 73, dated October 19, 2022, revealed that he was ordered an anti-emetic (vomiting) medication for calming, to be administered once every eight hours if needed. A nursing note for Resident 73, dated October 26, 2022, revealed that he called staff derogatory names and threatened to put a gun to their head and blow their brains out. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A nursing note for Resident 73, dated November 10, 2022, revealed that he was yelling at Resident 71 when she placed her hands on his face and said, Shut up or I will claw your f*cking eyes out. She then pushed his face away. A nursing note for Resident 73, dated November 11, 2022, revealed that his brother did not want Resident 73 moved out of his current room that he shared with Resident 71. He stated that he would talk to his family about having a one-on-one come into the building. Resident 73's sister then phoned and stated she did not want a room move or to have Resident 73 separated from Resident 71. A nursing note for Resident 73, dated November 16, 2022, revealed that his siblings all agreed that Resident 73 could be medicated for his behaviors and that they did not want him separated from Resident 71. A nursing note for Resident 73, dated December 2, 2022, revealed that he had an increase in behaviors and that he and his mother continued to yell at each other, and they could not be redirected. Resident 73's sister was present, and they continued to yell. Despite the ongoing verbal abuse between Resident 73 and Resident 71, as well as nursing notes indicating that they observed physical contact between Resident 71 and Resident 73 when Resident 71 was agitated and frustrated with him, the facility failed to investigate the allegations of abuse of one another and failed to protect the residents from one another. An interview with the Nursing Home Administrator on December 6, 2022 at 12:00 p.m. revealed that the facility did not investigate each time Resident 71 was accused of having touched or slapped Resident 73 because they did not feel that she was abusive to him. She stated that she did discuss these behaviors with the family and that the siblings did not believe Resident 71 was an abusive woman. She further stated that they did not believe the statement that Resident 73 made when she stated that his mother masturbated him, therefore they did not do a formal investigation into the matter. 42 CFR 483.13 - Resident Behavior and Facility Practices, 10-1-1998 edition. 28 Pa. Code 201.14(c) Responsibility of licensee. 28 Pa. Code 201.18(e)(1) Management. 28 Pa. Code 211.12(d)(5) Nursing services.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 38012 Based on review of facility policies, clinical records, and facility investigation documents, as well as staff interviews, it was determined that the facility failed to ensure that staff reported an allegation of physical or verbal abuse in a timely manner for two of 47 residents reviewed (Residents 71, 73). Findings include: The facility's policy regarding abuse, dated February 17, 2022, indicated that any staff that had suspicion of abuse or neglect or exploitation was to immediately report the suspicion to the supervisor. The supervisor was to notify the appropriate office personnel. Nursing notes, dated April 7, 2022, revealed that Resident 71 and Resident 73 arrived at the facility around the same time and were placed in the same room together. Resident 71 is the mother of Resident 73. Interview with Family Member 1 on December 6, 2022, at 1:45 p.m. revealed that Resident 73 had no power of attorney or legal guardian. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 71, dated November 12, 2022, indicated that the resident was cognitively intact, required assistance from staff for daily care needs, had behaviors such as physical and verbal aggression towards others, and had diagnoses that included dementia. Resident 71's care plan for verbal and aggressive behaviors towards Resident 73, dated May 24, 2022, indicated that staff would monitor her aggressive behaviors towards him. A quarterly MDS assessment for Resident 73, dated August 11, 2022, indicated that the resident was cognitively intact, required extensive assistance from staff for care, had a feeding tube (a tube surgically placed into the stomach for nutrition), had behaviors such as verbal aggression, and had diagnoses that included cerebral palsy (injury at birth that causes difficulty with movement, muscle tone and posture), dementia with behavioral disturbance (memory loss), and dysphagia (swallowing difficulties). An interview with Family Member 1 on December 6, 2022, at 1:45 p.m. revealed that he did not want his mother and brother separated and he felt that they should remain in the same room. He stated that his mother would never hurt his brother. He said that he knew that his mother had dementia, but he did not think that her having dementia would alter her thought process or her ability to deal with stressful situations. He stated that Resident 73 was independent, enjoyed going for walks, was social in his neighborhood, and enjoyed going out to eat at restaurants. In December 2021 Resident 73 got COVID and became very ill. He was intubated and ended up with a feeding tube as well. He said that Resident 73 deteriorated significantly but because of his intellectual disabilities, Resident 73 does not understand what has happened to him or that he is not able to go home or go out to eat or just walk around anymore. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A nursing note for Resident 73, dated April 18, 2022, revealed that he had displayed verbal behaviors such as yelling out. A nursing note, dated April 21, 2022, revealed that Resident 73 was yelling out and threatening staff saying that he did not like anyone there and would get them all in serious trouble by saying they did sexual things to him. Staff were unable to calm him as he yelled, and he began to call the staff names. A nursing note for Resident 71, dated April 19, 2022, revealed that she did not want to be moved to another room away from Resident 73 (her son), despite the yelling and arguing between them. A nursing note for Resident 73, dated April 25, 2022, revealed that he was evaluated by speech therapy and determined that he was not safe to eat foods and that he would continue to require the feeding tube. His sister stated that she understood but still wanted him to have food. A nursing note for Resident 73, dated May 1, 2022, revealed that his family requested he be served food regardless of his risk of aspiration (choking on the food). A nursing note, dated May 6, 2022, revealed that Resident 73 was yelling out and Resident 71 began yelling at him, which increased his behaviors. A nursing note for Resident 71, dated May 6, 2022, revealed that she was antagonizing Resident 73 when he was quiet and was heard saying piss your pants, that will get them in trouble. She was very argumentative with caretakers. A nursing note for Resident 73, dated May 6, 2022, revealed that he was yelling out and the nurse heard Resident 71 yell shut up you retard at him. A nursing note for Resident 73, dated May 7, 2022, revealed that he screamed continuously the entire shift and redirection and medication were ineffective. A nursing note for Resident 73, dated May 8, 2022, at 3:58 a.m. revealed that he yelled out the entire shift and was not able to be redirected. Other residents were upset and mad that they could not sleep. A nursing note for Resident 73, dated May 8, 2022, at 10:01 a.m. revealed that he was medicated to calm him, and that Resident 71 was found giving him drinks of water, despite his inability to swallow safely and the physician's order to not give him anything by mouth. A nursing note, dated May 12, 2022, revealed that Resident 73 and Resident 71 were yelling at each other and that despite the nurse's efforts she could not calm Resident 73. Resident 71 was very agitated and was telling Resident 73 to shut up, shut the hell up, these people hate you and don't want to come in because of you. When asked what she needed, Resident 71 stated him to shut the hell up. She then yelled at Resident 73 I hate you, you're just a waste of time, shut the hell up you idiot. A social service note for Resident 73, dated May 13, 2022, revealed that she phoned his sister to request a family meeting to discuss his behaviors. A social service note for Resident 73, dated May 17, 2022, revealed that a family meeting was held with his siblings. An individual caregiver was recommended to the family, and they were to investigate that suggestion. The family was to update the social worker regarding a one-on-one care intervention. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A nursing note for Resident 73, dated May 18, 2022, revealed that the nurse practitioner recommended medication changes and discussed this with his sister. However, on May 19, 2022, his sister decided she did not want any medication changes and wanted the medication discontinued. A nursing note for Resident 73, dated May 21, 2022, revealed that he was very agitated and continually screamed out all shift and was not able to be redirected. He continued to yell out all shift and began to make comments that his mother masturbated him and that he would say staff touched him sexually to get everyone in trouble. He could not be redirected. A nursing note for Resident 73, dated May 24, 2022, revealed that he continuously yelled throughout the shift and that he was not able to be consoled. He yelled at staff and called them names and yelled at Resident 71 as well. A nursing note for Resident 73, dated June 1, 2022, revealed that he continuously yelled out and had attention seeking behaviors. Resident 71 was overheard yelling shut up you retard to Resident 73, which aggravated him more. When the nurse attempted to educate Resident 71 that she should not call him a retard, she replied, I call them like I see them. A nursing note for Resident 71, dated June 16, 2022, revealed that she was having an increase in behaviors and was trying to pull Resident 73 out of bed. She was confused and not easily redirected. Staff phoned her daughter to try to redirect and that was unsuccessful. A nursing note for Resident 73, dated June 23, 2022, revealed that he had increased yelling outbursts at staff and that numerous attempts to calm him were unsuccessful. At 8:15 p.m. the nurse charted that the resident could not be consoled and was continuing to yell and scream so much that he was sweating profusely. He was given one-on-one attention and care and he continued to scream. The family refused medication for behaviors. A nursing note for Resident 71, dated July 4, 2022, revealed that she was complaining of hand and wrist pain and was found to have slight bruising and swelling to the left hand and wrist. The licensed practical nurse stated that she observed Resident 71 slap Resident 73 across the face. A nursing note for Resident 71, dated July 5, 2022, revealed that the licensed practical nurse now stated she did not see her slap Resident 73, but she heard a slap sound and heard the resident say ouch. A nursing note for Resident 73, dated July 17, 2022, revealed that his family was feeding him food that was not pureed, which was his ordered consistency. A nursing note for Resident 71, dated July 26, 2022, revealed that she was cursing and yelling at staff and yelling at Resident 73 to shut up and called him stupid. A nursing note for Resident 73, dated July 31, 2022, revealed that he was demanding care from staff stating he was wet or soiled; however, when care was provided, he would be dry, and he would yell at the staff and call them swear words. He also continued to yell at his mother. A nursing note for Resident 73, dated August 8, 2022, revealed that he was yelling obscenities and upsetting other residents, unable to be calmed. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A nursing note for Resident 73, dated August 11, 2022, revealed that he was found to have cookies that were not pureed and when staff removed them for his safety he yelled and swore loudly and continuously. The speech therapist sat with him and fed him the cookie to try to calm him; however, he continued to yell and scream. A social service's note for Resident 73, dated August 14, 2022, revealed that he was yelling out and Resident 71 called him crazy and told him to shut up. A nursing note for Resident 73, dated August 16, 2022, revealed that he was having behaviors and could not be redirected. Staff phoned his family for assistance, and they stated they would try to come in. A nursing note for Resident 73, dated August 19, 2022, revealed that his sister told nursing staff that she and her siblings had been bringing him regular consistency food in, not pureed, and she would like his diet changed to regular. His sister was educated that he is at risk of aspiration and the family should not bring him in regular foods. A nursing note for Resident 73, dated August 22, 2022, revealed that the nursing staff phoned his sister to inform her that he had medication changes to help with his anxiety and behaviors. A nursing note for Resident 73, dated August 25, 2022, revealed that his sister phoned and again requested his diet be changed to regular because she has been feeding him regular foods. She was informed he would need a test to determine if he was safe on regular foods and she agreed. She was educated that he required pureed foods and nectar thick liquids at that time. A nursing note for Resident 73, dated August 28, 2022, revealed that he returned from a doctor appointment with two cans of regular soda. The soda was placed in the refrigerator for later use. Later that evening the resident fell while screaming they took my pop. A nursing note for Resident 73, dated September 6, 2022, revealed that his sister was observed feeding him a regular can of soda and that she was aware he was not supposed to have it. A nursing note for Resident 73, dated September 15, 2022, revealed that his sister was in to visit and left him with regular pop in his room. A nursing note for Resident 73, dated October 15, 2022, revealed that he continuously yelled and demanded soda. Staff explained he could not have regular soda and he was angry and stated that his sisters gave him regular soda and so should they. A nursing note for Resident 73, dated October 9, 2022, revealed that he returned from the hospital and was yelling out. His brother phoned the nurses and requested that Resident 73 be medicated with calming medication due to his yelling out and having behaviors. A nursing note for Resident 73, dated October 10, 2022, revealed that his sister did not want him to have calming medications. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A nursing note for Resident 73, dated October 17, 2022, revealed that his sister was upset because she believed the facility was over-medicating the resident and that he was sedated. She expressed anger regarding her brother making decisions regarding Resident 73's care. A nursing note for Resident 73, dated October 19, 2022, revealed that he was ordered an anti-emetic (vomiting) medication for calming, to be administered once every eight hours if needed. A nursing note for Resident 73, dated October 26, 2022, revealed that he called staff derogatory names and threatened to put a gun to their head and blow their brains out. A nursing note for Resident 73, dated November 10, 2022, revealed that he was yelling at Resident 71 when she placed her hands on his face and said, Shut up or I will claw your f*cking eyes out. She then pushed his face away. A nursing note for Resident 73, dated November 11, 2022, revealed that his brother did not want Resident 73 moved out of his current room that he shared with Resident 71. He stated that he would talk to his family about having a one-on-one come into the building. Resident 73's sister then phoned and stated she did not want a room move or to have Resident 73 separated from Resident 71. A nursing note for Resident 73, dated November 16, 2022, revealed that his siblings all agreed that Resident 73 could be medicated for his behaviors and that they did not want him separated from Resident 71. A nursing note for Resident 73, dated December 2, 2022, revealed that he had an increase in behaviors and that he and his mother continued to yell at each other, and they could not be redirected. Resident 73's sister was present, and they continued to yell. There was no documented evidence that the Department of Health was notified about the allegations of abuse for Resident 71 or Resident 73. Interview with the Nursing Home Administrator on December 6, 2022 at 12:00 p.m. confirmed that staff should report any allegation/observation of abuse immediately and that the administrative staff are to investigate and report it timely. She stated that they did report one incident that occurred between Resident 71 and Resident 73, but that she did not report any others because she did not feel it was abuse. 42 CFR 483.13 - Resident Behavior and Facility Practices, 10-1-1998 edition. 28 Pa. Code 201.14(c) Responsibility of licensee. 28 Pa. Code 201.18(e)(1) Management. 28 Pa. Code 211.12(d)(5) Nursing services.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. 38012 Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to conduct a thorough investigation into the abuse between two residents for two of 47 residents reviewed (Residents 71, 73). Findings include: The facility's policy regarding abuse and neglect, dated February 17, 2022, indicated that the facility maintained that all allegations of neglect and abuse were thoroughly investigated and appropriate actions were taken. Nursing notes, dated April 7, 2022, revealed that Resident 71 and Resident 73 arrived at the facility around the same time and were placed in the same room together. Resident 71 is the mother of Resident 73. Interview with Family Member 1 on December 6, 2022, at 1:45 p.m. revealed that Resident 73 had no power of attorney or legal guardian. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 71, dated November 12, 2022, indicated that the resident was cognitively intact, required assistance from staff for daily care needs, had behaviors such as physical and verbal aggression towards others, and had diagnoses that included dementia. Resident 71's care plan for verbal and aggressive behaviors towards Resident 73, dated May 24, 2022, indicated that staff would monitor her aggressive behaviors towards him. A quarterly MDS assessment for Resident 73, dated August 11, 2022, indicated that the resident was cognitively intact, required extensive assistance from staff for care, had a feeding tube (a tube surgically placed into the stomach for nutrition), had behaviors such as verbal aggression, and had diagnoses that included cerebral palsy (injury at birth that causes difficulty with movement, muscle tone and posture), dementia with behavioral disturbance (memory loss), and dysphagia (swallowing difficulties). An interview with Family Member 1 on December 6, 2022, at 1:45 p.m. revealed that he did not want his mother and brother separated and he felt that they should remain in the same room. He stated that his mother would never hurt his brother. He said that he knew that his mother had dementia, but he did not think that her having dementia would alter her thought process or her ability to deal with stressful situations. He stated that Resident 73 was independent, enjoyed going for walks, was social in his neighborhood, and enjoyed going out to eat at restaurants. In December 2021 Resident 73 got COVID and became very ill. He was intubated and ended up with a feeding tube as well. He said that Resident 73 deteriorated significantly but because of his intellectual disabilities, Resident 73 does not understand what has happened to him or that he is not able to go home or go out to eat or just walk around anymore. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A nursing note for Resident 73, dated April 18, 2022, revealed that he had displayed verbal behaviors such as yelling out. A nursing note, dated April 21, 2022, revealed that Resident 73 was yelling out and threatening staff saying that he did not like anyone there and would get them all in serious trouble by saying they did sexual things to him. Staff were unable to calm him as he yelled, and he began to call the staff names. A nursing note for Resident 71, dated April 19, 2022, revealed that she did not want to be moved to another room away from Resident 73 (her son), despite the yelling and arguing between them. A nursing note for Resident 73, dated April 25, 2022, revealed that he was evaluated by speech therapy and determined that he was not safe to eat foods and that he would continue to require the feeding tube. His sister stated that she understood but still wanted him to have food. A nursing note for Resident 73, dated May 1, 2022, revealed that his family requested he be served food regardless of his risk of aspiration (choking on the food). A nursing note, dated May 6, 2022, revealed that Resident 73 was yelling out and Resident 71 began yelling at him, which increased his behaviors. A nursing note for Resident 71, dated May 6, 2022, revealed that she was antagonizing Resident 73 when he was quiet and was heard saying piss your pants, that will get them in trouble. She was very argumentative with caretakers. A nursing note for Resident 73, dated May 6, 2022, revealed that he was yelling out and the nurse heard Resident 71 yell shut up you retard at him. A nursing note for Resident 73, dated May 7, 2022, revealed that he screamed continuously the entire shift and redirection and medication were ineffective. A nursing note for Resident 73, dated May 8, 2022, at 3:58 a.m. revealed that he yelled out the entire shift and was not able to be redirected. Other residents were upset and mad that they could not sleep. A nursing note for Resident 73, dated May 8, 2022, at 10:01 a.m. revealed that he was medicated to calm him, and that Resident 71 was found giving him drinks of water, despite his inability to swallow safely and the physician's order to not give him anything by mouth. A nursing note, dated May 12, 2022, revealed that Resident 73 and Resident 71 were yelling at each other and that despite the nurse's efforts she could not calm Resident 73. Resident 71 was very agitated and was telling Resident 73 to shut up, shut the hell up, these people hate you and don't want to come in because of you. When asked what she needed, Resident 71 stated him to shut the hell up. She then yelled at Resident 73 I hate you, you're just a waste of time, shut the hell up you idiot. A social service note for Resident 73, dated May 13, 2022, revealed that she phoned his sister to request a family meeting to discuss his behaviors. A social service note for Resident 73, dated May 17, 2022, revealed that a family meeting was held with his siblings. An individual caregiver was recommended to the family, and they were to investigate that suggestion. The family was to update the social worker regarding a one-on-one care intervention. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A nursing note for Resident 73, dated May 18, 2022, revealed that the nurse practitioner recommended medication changes and discussed this with his sister. However, on May 19, 2022, his sister decided she did not want any medication changes and wanted the medication discontinued. A nursing note for Resident 73, dated May 21, 2022, revealed that he was very agitated and continually screamed out all shift and was not able to be redirected. He continued to yell out all shift and began to make comments that his mother masturbated him and that he would say staff touched him sexually to get everyone in trouble. He could not be redirected. A nursing note for Resident 73, dated May 24, 2022, revealed that he continuously yelled throughout the shift and that he was not able to be consoled. He yelled at staff and called them names and yelled at Resident 71 as well. A nursing note for Resident 73, dated June 1, 2022, revealed that he continuously yelled out and had attention seeking behaviors. Resident 71 was overheard yelling shut up you retard to Resident 73, which aggravated him more. When the nurse attempted to educate Resident 71 that she should not call him a retard, she replied, I call them like I see them. A nursing note for Resident 71, dated June 16, 2022, revealed that she was having an increase in behaviors and was trying to pull Resident 73 out of bed. She was confused and not easily redirected. Staff phoned her daughter to try to redirect and that was unsuccessful. A nursing note for Resident 73, dated June 23, 2022, revealed that he had increased yelling outbursts at staff and that numerous attempts to calm him were unsuccessful. At 8:15 p.m. the nurse charted that the resident could not be consoled and was continuing to yell and scream so much that he was sweating profusely. He was given one-on-one attention and care and he continued to scream. The family refused medication for behaviors. A nursing note for Resident 71, dated July 4, 2022, revealed that she was complaining of hand and wrist pain and was found to have slight bruising and swelling to the left hand and wrist. The licensed practical nurse stated that she observed Resident 71 slap Resident 73 across the face. A nursing note for Resident 71, dated July 5, 2022, revealed that the licensed practical nurse now stated she did not see her slap Resident 73, but she heard a slap sound and heard the resident say ouch. A nursing note for Resident 73, dated July 17, 2022, revealed that his family was feeding him food that was not pureed, which was his ordered consistency. A nursing note for Resident 71, dated July 26, 2022, revealed that she was cursing and yelling at staff and yelling at Resident 73 to shut up and called him stupid. A nursing note for Resident 73, dated July 31, 2022, revealed that he was demanding care from staff stating he was wet or soiled; however, when care was provided, he would be dry, and he would yell at the staff and call them swear words. He also continued to yell at his mother. A nursing note for Resident 73, dated August 8, 2022, revealed that he was yelling obscenities and upsetting other residents, unable to be calmed. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A nursing note for Resident 73, dated August 11, 2022, revealed that he was found to have cookies that were not pureed and when staff removed them for his safety he yelled and swore loudly and continuously. The speech therapist sat with him and fed him the cookie to try to calm him; however, he continued to yell and scream. A social service's note for Resident 73, dated August 14, 2022, revealed that he was yelling out and Resident 71 called him crazy and told him to shut up. A nursing note for Resident 73, dated August 16, 2022, revealed that he was having behaviors and could not be redirected. Staff phoned his family for assistance, and they stated they would try to come in. A nursing note for Resident 73, dated August 19, 2022, revealed that his sister told nursing staff that she and her siblings had been bringing him regular consistency food in, not pureed, and she would like his diet changed to regular. His sister was educated that he is at risk of aspiration and the family should not bring him in regular foods. A nursing note for Resident 73, dated August 22, 2022, revealed that the nursing staff phoned his sister to inform her that he had medication changes to help with his anxiety and behaviors. A nursing note for Resident 73, dated August 25, 2022, revealed that his sister phoned and again requested his diet be changed to regular because she has been feeding him regular foods. She was informed he would need a test to determine if he was safe on regular foods and she agreed. She was educated that he required pureed foods and nectar thick liquids at that time. A nursing note for Resident 73, dated August 28, 2022, revealed that he returned from a doctor appointment with two cans of regular soda. The soda was placed in the refrigerator for later use. Later that evening the resident fell while screaming they took my pop. A nursing note for Resident 73, dated September 6, 2022, revealed that his sister was observed feeding him a regular can of soda and that she was aware he was not supposed to have it. A nursing note for Resident 73, dated September 15, 2022, revealed that his sister was in to visit and left him with regular pop in his room. A nursing note for Resident 73, dated October 15, 2022, revealed that he continuously yelled and demanded soda. Staff explained he could not have regular soda and he was angry and stated that his sisters gave him regular soda and so should they. A nursing note for Resident 73, dated October 9, 2022, revealed that he returned from the hospital and was yelling out. His brother phoned the nurses and requested that Resident 73 be medicated with calming medication due to his yelling out and having behaviors. A nursing note for Resident 73, dated October 10, 2022, revealed that his sister did not want him to have calming medications. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A nursing note for Resident 73, dated October 17, 2022, revealed that his sister was upset because she believed the facility was over-medicating the resident and that he was sedated. She expressed anger regarding her brother making decisions regarding Resident 73's care. A nursing note for Resident 73, dated October 19, 2022, revealed that he was ordered an anti-emetic (vomiting) medication for calming, to be administered once every eight hours if needed. A nursing note for Resident 73, dated October 26, 2022, revealed that he called staff derogatory names and threatened to put a gun to their head and blow their brains out. A nursing note for Resident 73, dated November 10, 2022, revealed that he was yelling at Resident 71 when she placed her hands on his face and said, Shut up or I will claw your f*cking eyes out. She then pushed his face away. A nursing note for Resident 73, dated November 11, 2022, revealed that his brother did not want Resident 73 moved out of his current room that he shared with Resident 71. He stated that he would talk to his family about having a one-on-one come into the building. Resident 73's sister then phoned and stated she did not want a room move or to have Resident 73 separated from Resident 71. A nursing note for Resident 73, dated November 16, 2022, revealed that his siblings all agreed that Resident 73 could be medicated for his behaviors and that they did not want him separated from Resident 71. A nursing note for Resident 73, dated December 2, 2022, revealed that he had an increase in behaviors and that he and his mother continued to yell at each other, and they could not be redirected. Resident 73's sister was present, and they continued to yell. Interview with Nurse Aide 4 on December 5, 2022, at 3:48 p.m. revealed that Residents 71 and 73 often yell at each other and that she tries to separate them; however, they do not like to leave their room. She said that there are family members that visit, but they are not able to get them to stop yelling at each other either. She said the family instigates the residents by bringing food and drink items in for Resident 73 that he cannot have because he is on pureed diet with thickened liquids, then Resident 73 gets angry when staff have to take the items. Then Resident 71 yells at them all. Interview with Nurse Aide 5 on December 5, 2022, at 3:52 p.m. revealed that Resident 71 and Resident 73 constantly yell at each other, and the staff are not able to redirect them. She stated that Resident 73 gets angry that Resident 71 yells at him and then he yells more. She said Resident 71 yells at Resident 73 and calls him names. Interview with Registered Nurse 6 on December 5, 2022, at 4:17 p.m. revealed that Resident 73 yells a lot and that Resident 71 yells and swears at him to shut up and calls him names. She said that recently a nurse aide came to get her because the nurse aide witnessed Resident 71 with her hands on Resident 73's neck telling him to shut up and calling him names. She said she wanted to separate the residents since they room together and constantly yell at one another, but administration told her she is not permitted to move either of them. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There was no documented evidence that administration conducted thorough investigations regarding the many reported incidents of verbal and physical abuse between Resident 71 and Resident 73 by the staff. Interview with the Nursing Home Administrator on December 6, 2022 at 12:00 p.m. confirmed that there were no investigations into the many reports of verbal and physical abuse between Resident 71 and Resident 73. 42 CFR 483.13 - Resident Behavior and Facility Practices, 10-1-1998 edition. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1) Management. 28 Pa. Code 201.18(e)(1) Management. 28 Pa. Code 207.2(a) Administrator's responsibility. 28 Pa. Code 211.12(d)(3) Nursing services. 28 Pa. Code 211.12(d)(5) Nursing services.

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F 0742 Level of Harm - Actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. 28177 Based on clinical record reviews as well as interviews with staff, it was determined that the facility failed to adequately monitor, assess, and provide the necessary and timely behavioral health care and services for residents exhibiting psychological and/or physical distress for two of 47 residents reviewed (Residents 71 and 73). Findings include: Nursing notes, dated April 7, 2022, revealed that Resident 71 and Resident 73 arrived at the facility around the same time and were placed in the same room together. Resident 71 is the mother of Resident 73. Interview with Family Member 1 on December 6, 2022, at 1:45 p.m. revealed that Resident 73 had no power of attorney or legal guardian. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 71, dated November 12, 2022, indicated that the resident was cognitively intact, required assistance from staff for daily care needs, had behaviors such as physical and verbal aggression towards others, and had diagnoses that included dementia. Resident 71's care plan for verbal and aggressive behaviors towards Resident 73, dated May 24, 2022, indicated that staff would monitor her aggressive behaviors towards him. A quarterly MDS assessment for Resident 73, dated August 11, 2022, indicated that the resident was cognitively intact, required extensive assistance from staff for care, had a feeding tube (a tube surgically placed into the stomach for nutrition), had behaviors such as verbal aggression, and had diagnoses that included cerebral palsy (injury at birth that causes difficulty with movement, muscle tone and posture), dementia with behavioral disturbance (memory loss), and dysphagia (swallowing difficulties). An interview with Family Member 1 on December 6, 2022, at 1:45 p.m. revealed that he did not want his mother and brother separated and he felt that they should remain in the same room. He stated that his mother would never hurt his brother. He said that he knew that his mother had dementia, but he did not think that her having dementia would alter her thought process or her ability to deal with stressful situations. He stated that Resident 73 was independent, enjoyed going for walks, was social in his neighborhood, and enjoyed going out to eat at restaurants. In December 2021 Resident 73 got COVID and became very ill. He was intubated and ended up with a feeding tube as well. He said that Resident 73 deteriorated significantly but because of his intellectual disabilities, Resident 73 does not understand what has happened to him or that he is not able to go home or go out to eat or just walk around anymore. A nursing note for Resident 73, dated April 18, 2022, revealed that he had displayed verbal behaviors such as yelling out. A nursing note dated April 21, 2022, revealed that Resident 73 was yelling out and threatening staff saying that he did not like anyone there and would get them all in serious trouble by saying they did sexual things to him. Staff were unable to calm him as he yelled, and he began to call the staff names. (continued on next page)

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F 0742 Level of Harm - Actual harm Residents Affected - Few	A nursing note for Resident 73, dated October 17, 2022, revealed that his sister was upset because she believed the facility was over-medicating the resident and that he was sedated. She expressed anger regarding her brother making decisions regarding Resident 73's care. A nursing note for Resident 73, dated October 19, 2022, revealed that he was ordered an anti-emetic (vomiting) medication for calming, to be administered once every eight hours if needed. A nursing note for Resident 73, dated October 26, 2022, revealed that he called staff derogatory names and threatened to put a gun to their head and blow their brains out. A nursing note for Resident 73, dated November 10, 2022, revealed that he was yelling at Resident 71 when she placed her hands on his face and said, shut up or I will claw your f*cking eyes out. She then pushed his face away. A nursing note for Resident 73, dated November 11, 2022, revealed that his brother did not want Resident 73 moved out of his current room that he shared with Resident 71. He stated that he would talk to his family about having a one-on-one come into the building. Resident 73's sister then phoned and stated she did not want a room move or to have Resident 73 separated from Resident 71. A nursing note for Resident 73, dated November 16, 2022, revealed that his siblings all agreed that Resident 73 could be medicated for his behaviors and that they did not want him separated from Resident 71. A nursing note for Resident 73, dated December 2, 2022, revealed that he had an increase in behaviors and that he and his mother continued to yell at each other, and they could not be redirected. Resident 73's sister was present, and they continued to yell. Despite the ongoing verbal abuse between Resident 73 and Resident 71, as well as nursing notes indicating that they observed physical contact between Resident 71 and Resident 73 when Resident 71 was agitated and frustrated with him, the facility allowed the residents to remain in the same room with each other. A care plan for Resident 71's verbal and aggressive behaviors towards Resident 73, dated May 24, 2022, indicated that staff would monitor her aggressive behaviors towards him; however, there was no documented evidence that her behaviors were monitored. According to the nursing notes above, staff were unable to redirect Resident 71 or calm her when Resident 73 was yelling out. There was no documented evidence that a care plan addressing Resident 73's behavior was developed until November 6, 2022, seven months after his behaviors began and it had not been revised to reflect any new interventions since that time. There was no documented evidence that Resident 73's behaviors were being monitored. According to the nursing notes above, staff were never able to redirect him or calm him. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395500	A. Building B. Wing	12/07/2022

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0742 Level of Harm - Actual harm Residents Affected - Few	During the interview with Family Member 1 on December 6, 2022, at 1:45 p.m. he also stated that he believes Resident 73 yells and screams all the time because he can no longer go home or out to eat or for a walk. He further said that he believes Resident 71 gets upset with Resident 73 because she must listen to him scream all day and all night. Family Member 1 stated that Resident 73 had no power of attorney or legal guardian. Family Member 1 stated that he was the power of attorney for Resident 71, and he thought that gave him the ability to make decisions for Resident 73 as well; however, his siblings were also making decisions for Resident 73, and they would often contradict one another. Family Member 1 stated he thought about getting guardianship for Resident 73, but he was unsure how to go about it and the facility never mentioned that that was an option or that it was important so that one person was making decisions while another family member changed the plan. The facility indicated that they had interventions in place and that Resident 71's and Resident 73's care plans were updated with interventions to prevent further behaviors by either resident; however, a review of the care plans provided revealed that neither resident had any changes regarding their behaviors towards one another. Interview with Nurse Aide 4 on December 5, 2022, at 3:48 p.m. revealed that Residents 71 and 73 often yell at each other and that she tries to separate them; however, they do not like to leave their room. She said that there are family members that visit, but they are not able to get them to stop yelling at each other either. She said the family instigates the residents by bringing food and drink items in for Resident 73 that he cannot have because he is on pureed diet with thickened liquids, then Resident 73 gets angry when staff have to take the items. Then Resident 71 yells at them all. Interview with Nurse Aide 5 on December 5, 2022, at 3:52 p.m. revealed that Resident 71 and Resident 73 constantly yell at each other, and the staff are not able to redirect them. She stated that Resident 73 gets angry that Resident 71 yells at him and then he yells more. She said Resident 71 yells at Resident 73 and calls him names. Interview with Registered Nurse 6 on December 5, 2022, at 4:17 p.m. revealed that Resident 73 yells a lot and that Resident 71 yells and swears at him to shut up and calls him names. She said that recently a nurse aide came to get her because the nurse aide witnessed Resident 71 with her hands on Resident 73's neck telling him to shut up and calling him names. She said she wanted to separate the residents since they room together and constantly yell at one another, but administration told her she is not permitted to move either of them. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(e)(1) Management. 28 Pa. Code 201.29(a)(c)(d) Resident rights.