Printed: 11/22/2024 Form Approved OMB No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395500	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/07/2022
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 con	tact 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	and neglect by anybody. 38012 Based on a review of facility policie resident and staff interviews, it was protect residents from verbal and p (Residents 71, 73). This failure pla physical abuse that already occurred. Findings include: Review of the facility's abuse policy free from abuse and neglect. Nursing notes, dated April 7, 2022, the same time and were placed in Interview with Family Member 1 or of attorney or legal guardian. A quarterly Minimum Data Set (MD needs) for Resident 71, dated Nova assistance from staff for daily care others, and had diagnoses that included behaviors towards Resident 73, date behaviors towards him. A quarterly MDS assessment for Recognitively intact, required extensively placed into the stomach for nutrition included cerebral palsy (injury at bit included cerebral palsy (injury at bit included cerebral palsy).	es, clinical records, and information substances, clinical records, and information substances determined that the facility failed to prohysical abuse after abuse was identified the residents in immediate jeoparded, as well as the potential for further very, dated February 17, 2022, revealed the revealed that Resident 71 and Resident estances are room together. Resident 71 in December 6, 2022, at 1:45 p.m. revealed that the resineeds, had behaviors such as physical luded dementia. Resident 71's care plated May 24, 2022, indicated that staff very assistance from staff for care, had a nn), had behaviors such as verbal aggreatiff that causes difficulty with movementice (memory loss), and dysphagia (swarp in the content of the content	omitted by the facility, as well as omptly take measures necessary to ad for two of 47 residents reviewed y due to the actual verbal and erbal and physical abuse to occur. That residents have the right to be not 73 arrived at the facility around as the mother of Resident 73. The facility around is the mother of Resident 73 had no power alled that Resident's abilities and care dent was cognitively intact, required I and verbal aggression towards in for verbal and aggressive would monitor her aggressive would monitor her aggressive licated that the resident was feeding tube (a tube surgically ession, and had diagnoses that att, muscle tone and posture),

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

FORM CMS-2567 (02/99) Previous Versions Obsolete Event ID:

Facility ID: 395500

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395500	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/07/2022
NAME OF PROVIDER OR SUPPLIE		STREET ADDRESS CITY STATE 71	D CODE
		STREET ADDRESS, CITY, STATE, ZI 227 Sand Hill Road	PCODE
Twin Lakes Rehabilitation and Healthcare Center		Greensburg, PA 15601	
For information on the nursing home's	For information on the nursing home's plan to correct this deficiency, please con-		agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		on)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An interview with Family Member 1 mother and brother separated and mother would never hurt his brothe that her having dementia would alte stated that Resident 73 was indepenjoyed going out to eat at restaura was intubated and ended up with a but because of his intellectual disal that he is not able to go home or go. A nursing note for Resident 73, dat as yelling out. A nursing note, date threatening staff saying that he did they did sexual things to him. Staff names. A nursing note for Resident 71, dat room away from Resident 73 (her sexual that he was not safe to sister stated that he was not safe to sister stated that she understood be a nursing note for Resident 73, dat regardless of his risk of aspiration (A nursing note, dated May 6, 2022 at him, which increased his behavious antagonizing Resident 73 whe trouble. She was very argumentative A nursing note for Resident 73, dat Resident 71 yell shut up you retard A nursing note for Resident 73, dat and redirection and medication were and was not able to be redirected. A nursing note for Resident 73, dat and was not able to be redirected.	on December 6, 2022, at 1:45 p.m. reine felt that they should remain in the said. He said that he knew that his mother er her thought process or her ability to dendent, enjoyed going for walks, was so ants. In December 2021 Resident 73 going feeding tube as well. He said that Residentials, Resident 73 does not understand out to eat or just walk around anymore and April 18, 2022, revealed that he had a April 21, 2022, revealed that Residentials anyone there and would get the were unable to calm him as he yelled, and April 19, 2022, revealed that she did son), despite the yelling and arguing be seed April 25, 2022, revealed that he was eat foods and that he would continue that still wanted him to have food. The ded May 1, 2022, revealed that his familiation on the food). The was quiet and was heard saying prove with caretakers. The day 6, 2022, revealed that he was a lat him. The day 7, 2022, revealed that he was a lat him. The day 7, 2022, revealed that he was a lat him. The day 7, 2022, revealed that he was a lat him. The day 8, 2022, at 3:58 a.m. revealed other residents were upset and mad the lated May 8, 2022, at 10:01 a.m. revealed and giving him drinks of water, despite him and the lated May 8, 2022, at 10:01 a.m. revealed and giving him drinks of water, despite him and the lated May 8, 2022, at 10:01 a.m. revealed and giving him drinks of water, despite him and the lated May 8, 2022, at 10:01 a.m. revealed and giving him drinks of water, despite him and the lated May 8, 2022, at 10:01 a.m. revealed and giving him drinks of water, despite him and the lated May 8, 2022, at 10:01 a.m. revealed and giving him drinks of water, despite him and the lated May 8, 2022, at 10:01 a.m. revealed and giving him drinks of water, despite him and the lated May 8, 2022, at 10:01 a.m. revealed and giving him drinks of water, despite him and the lated May 8, 2022, at 10:01 a.m. revealed and giving him drinks of water, despite him and the lated May 8, 2022, at 10:01 a.m.	vealed that he did not want his ame room. He stated that his had dementia, but he did not think deal with stressful situations. He ocial in his neighborhood, and of COVID and became very ill. He ident 73 deteriorated significantly and what has happened to him or e. I displayed verbal behaviors such at 73 was yelling out and em all in serious trouble by saying and he began to call the staff and not want to be moved to another tween them. Is evaluated by speech therapy and o require the feeding tube. His are larger than the poiss your pants, that will get them in the yelling out and the nurse heard are continuously the entire shift that he yelled out the entire shift that he yelled out sleep.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	395500	A. Building	12/07/2022	
	000000	B. Wing	1-7117-1-1	
NAME OF PROVIDER OR SUPPLII	ER	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 con	tact 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	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.			
Residents Affected - Some	A social service note for Resident 7 family meeting to discuss his behavior	73, dated May 13, 2022, revealed that viors.	she phoned his sister to request a	
	siblings. An individual caregiver wa	73, dated May 17, 2022, revealed that a ss recommended to the family, and they ate the social worker regarding a one-o	y were to investigate that	
	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.			
		ted June 16, 2022, revealed that she wout of bed. She was confused and not 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 pa 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.			
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STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. Building	COMPLETED	
	395500	B. Wing	12/07/2022	
NAME OF PROVIDER OR SUPPLIE	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 con	tact 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	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.			
Level of Harm - Immediate jeopardy to resident health or safety	A nursing note for Resident 73, dat not pureed, which was his ordered	ed July 17, 2022, revealed that his fam consistency.	ily was feeding him food that was	
Residents Affected - Some	A nursing note for Resident 71, dat yelling at Resident 73 to shut up ar	ed July 26, 2022, revealed that she wand called him stupid.	s cursing and yelling at staff and	
	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.			
		ed August 16, 2022, revealed that he villy for assistance, and they stated they		
	her siblings had been bringing him	or Resident 73, dated August 19, 2022, revealed that his sister told nursing staff that she and been bringing him regular consistency food in, not pureed, and she would like his diet lar. His sister was educated that he is at risk of aspiration and the family should not bring ods.		
	,	ed August 22, 2022, revealed that the changes to help with his anxiety and be	0 1	
	A nursing note for Resident 73, dated August 25, 2022, revealed that his sister phoned and again request his diet be changed to regular because she has been feeding him regular foods. She was informed he wo need a test to determine if he was safe on regular foods and she agreed. She was educated that he requipureed 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 appoint with two cans of regular soda. The soda was placed in the refrigerator for later use. Later that evening t resident fell while screaming they took my pop.			
		Resident 73, dated September 6, 2022, revealed that his sister was observed feeding him oda and that she was aware he was not supposed to have it.		
	(continued on next page)			

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, <u>-</u> , <u>-</u> , <u>-</u> ,	395500	A. Building	12/07/2022	
	000000	B. Wing		
NAME OF PROVIDER OR SUPPLII	NAME OF PROVIDER OR SUPPLIER		P 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 con	tact 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)			
	(Edon denoising) made be preceded by	Tuning and to the factor of th		
F 0600 Level of Harm - Immediate	A nursing note for Resident 73, dated September 15, 2022, revealed that his sister was in to visit and left h with regular pop in his room.			
jeopardy to resident health or		ted October 15, 2022, revealed that he		
safety	soda. Staff explained he could not regular soda and so should they.	have regular soda and he was angry a	nd stated that his sisters gave him	
Residents Affected - Some	A nursing note for Resident 73. dat	ted October 9, 2022, revealed that he re	eturned from the hospital and was	
		nurses and requested that Resident 73		
	A nursing note for Resident 73, dat calming medications.	ed October 10, 2022, revealed that his	sister did not want him to have	
	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.			
		red October 19, 2022, revealed that he to be administered once every eight ho		
	A nursing note for Resident 73, dat threatened to put a gun to their hea	red October 26, 2022, revealed that he ad and blow their brains out.	called staff derogatory names and	
	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 R 73 moved out of his current room that he shared with Resident 71. He stated that he would talk to I about having a one-on-one come into the building. Resident 73's sister then phoned and stated showant a room move or to have Resident 73 separated from Resident 71.			
	1	ed November 16, 2022, revealed that haviors and that they did not want him se		
	1	ted December 2, 2022, revealed that he by yell at each other, and they could not by yell.		
	Despite the ongoing verbal abuse between Resident 73 and Resident 71, as well as nursing notes indic that they observed physical contact between Resident 71 and Resident 73 when Resident 71 was agitar and frustrated with him, the facility allowed the residents to remain in the same room with each other.			
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NAME OF PROVIDER OR SUPPLII	FD.	STREET ADDRESS, CITY, STATE, ZI	P CODE	
Twin Lakes Rehabilitation and Healthcare Center		227 Sand Hill Road Greensburg, PA 15601	FCODE	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			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	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.			
Residents Affected - Some	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 ye at each other and that she tries to separate them; however, they do not like to leave their room. She said 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 nursaide 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 roc together and constantly yell at one another, but administration told her she is not permitted to move either them.			
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FORM CMS-2567 (02/99) Previous Versions Obsolete Event ID:

Facility ID: 395500

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395500	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/07/2022	
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 con	tact 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	An Immediate Jeopardy situation was identified to the Nursing Home Administrator and the Director Nursing on December 6, 2022, at 12:20 p.m. related to the facility's failure to ensure that immediate adequate safeguards were taken to protect Resident 73 from potential physical and verbal abuse by his mother. Nursing staff observed multiple occasions of verbal abuse by both Resident 71 and well as Resident 71 getting frustrated and grabbing at or slapping at Resident 73 to get his attention tell him to shut up. The corrective action plan included the following interventions:			
	·	pervision to monitor Residents 71 and	73 when together until an alternate	
	The facility ordered immediate psyc	chological 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 ed contact with residents until all staff	ducation on abuse on the beginning of have been re-educated.	their shift prior to having any	
	Administrative staff conducted a far at risk of physical, verbal abuse, ar	cility-wide audit 30 days retroactively to id/or psychosocial harm.	o identify other residents that were	
	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 comple 3:00 p.m. on December 7, 2022.	tion of this corrective action plan the ir	nmediate jeopardy was lifted at	
	42 CFR 483.13 - Resident Behavio	r and Facility Practices, 10-1-1998 edi	tion.	
	28 Pa. Code 201.14(a) Responsibi	lity of licensee.		
	28 Pa. Code 201.18(e)(1) Manager	ment.		
	28 Pa. Code 201.29(a)(c)(d) Resident rights.			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. Building	(X3) DATE SURVEY COMPLETED 12/07/2022	
	395500	B. Wing	12/01/2022	
NAME OF PROVIDER OR SUPPLII	÷ ER	STREET ADDRESS, CITY, STATE, ZI	P 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	Develop and implement policies ar	Develop and implement policies and procedures to prevent abuse, neglect, and theft.		
Level of Harm - Minimal harm or potential for actual harm	38012			
Residents Affected - Some	it was determined that the facility fa	clinical records, and investigation docu ailed to implement its abuse policy by n for two of 47 residents reviewed (Resid	ot immediately protecting residents	
	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.			
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STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. Building	COMPLETED	
	395500	B. Wing	12/07/2022	
NAME OF PROVIDER OR SUPPLIE	ER	STREET ADDRESS, CITY, STATE, ZIP CODE		
Twin Lakes Rehabilitation and Hea	althcare 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	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.			
potential for actual harm Residents Affected - Some	A nursing note for Resident 73, dat regardless of his risk of aspiration (ted May 1, 2022, revealed that his fami (choking on the food).	ly requested he be served 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, dat Resident 71 yell shut up you retard	ted May 6, 2022, revealed that he was lat him.	yelling out and the nurse heard	
	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.			
	and that despite the nurse's efforts telling Resident 73 to shut up, shut you. When asked what she needed	y 12, 2022, revealed that Resident 73 and Resident 71 were yelling at each other e's efforts she could not calm Resident 73. Resident 71 was very agitated and was tup, shut the hell up, these people hate you and don't want to come in because of the needed, Resident 71 stated him to shut the hell up. She then yelled at Resident as waste of time, shut the hell up you idiot.		
	A social service note for Resident 7 family meeting to discuss his behave	73, dated May 13, 2022, revealed that sviors.	she phoned his sister to request a	
	siblings. An individual caregiver wa	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 do not want any medication changes and wanted the medication discontinued.		
	medication changes and discussed			
	screamed out all shift and was not	73, dated May 21, 2022, revealed that he was very agitated and continually as not able to be redirected. He continued to yell out all shift and began to make asturbated him and that he would say staff touched him sexually to get everyone directed.		
	(continued on next page)			

			NO. 0936-0391
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 12/07/2022
NAME OF PROVIDER OR SUPPLIER Twin Lakes Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZI 227 Sand Hill Road Greensburg, PA 15601	P CODE
For information on the nursing home's	plan to correct this deficiency, please con	tact 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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and that he was not able to be consas well. A nursing note for Resident 73, dat attention seeking behaviors. Reside aggravated him more. When the nuretard, she replied, I call them like I A nursing note for Resident 71, dat and was trying to pull Resident 73 daughter to try to redirect and that the A nursing note for Resident 73, dat staff and that numerous attempts to resident could not be consoled and profusely. He was given one-on-on medication for behaviors. A nursing note for Resident 71, dat and was found to have slight bruisi stated that she observed Resident A nursing note for Resident 71, dat did not see her slap Resident 73, dat not pureed, which was his ordered A nursing note for Resident 73, dat he was wet or soiled; however, who call them swear words. He also cor A nursing note for Resident 73, dat other residents, unable to be calmed A nursing note for Resident 73, dat were not pureed and when staff rer The speech therapist sat with him and scream.	led June 16, 2022, revealed that she wout of bed. She was confused and not was unsuccessful. It ded June 23, 2022, revealed that he has be calm him were unsuccessful. At 8:15 I was continuing to yell and scream so e attention and care and he continued and seed July 4, 2022, revealed that she was not and swelling to the left hand and wr 71 slap Resident 73 across the face. It was continuing to yell and scream so e attention and care and he continued and swelling to the left hand and wr 71 slap Resident 73 across the face. It was continued to get a seed July 5, 2022, revealed that the licer ut she heard a slap sound and heard to get July 17, 2022, revealed that his famiconsistency. It was continued to get a seed July 31, 2022, revealed that he was en care was provided, he would be dryntinued to yell at his mother. It was continued to get a seed August 11, 2022, revealed that he was en care was provided, he would be dryntinued to yell at his mother. It was continued to get a seed August 11, 2022, revealed that he was en care was provided, he would be dryntinued to yell at his mother. It was continued to get a seed a seed August 11, 2022, revealed that he was end and fed him the cookie to try to calm him and fed him the cooki	innuously yelled out and had ou retard to Resident 73, which that she should not call him a as having an increase in behaviors easily redirected. Staff phoned her dincreased yelling outbursts at p.m. the nurse charted that the much that he was sweating to scream. The family refused a complaining of hand and wrist pain ist. The licensed practical nurse used practical nurse now stated she he resident say ouch. The licensed practical nurse now stated she he resident say ouch. The licensed practical nurse as a cursing and yelling at staff and as yelling obscenities and upsetting was found to have cookies that diswore loudly and continuously. The licensed practical nurse now stated she he resident say ouch. The licensed practical nurse now stated she he resident say ouch. The licensed practical nurse now stated she he resident say ouch. The licensed practical nurse now stated she he resident say ouch. The licensed practical nurse now stated she he resident say ouch. The licensed practical nurse now stated she he resident say ouch. The licensed practical nurse now stated she he resident say ouch. The licensed practical nurse now stated she he resident say ouch. The licensed practical nurse now stated she he resident say ouch. The licensed practical nurse now stated she he resident say ouch. The licensed practical nurse now stated she he resident say ouch.

			NO. 0936-0391
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 12/07/2022
NAME OF PROVIDER OR SUPPLIER Twin Lakes Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZI 227 Sand Hill Road Greensburg, PA 15601	P CODE
For information on the nursing home's	plan to correct this deficiency, please con	tact 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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	be redirected. Staff phoned his fam A nursing note for Resident 73, dat her siblings had been bringing him changed to regular. His sister was him in regular foods. A nursing note for Resident 73, dat inform her that he had medication of A nursing note for Resident 73, dat his diet be changed to regular beca- need a test to determine if he was pureed foods and nectar thick liquir A nursing note for Resident 73, dat with two cans of regular soda. The resident fell while screaming they to A nursing note for Resident 73, dat a regular can of soda and that she A nursing note for Resident 73, dat with regular pop in his room. A nursing note for Resident 73, dat soda. Staff explained he could not regular soda and so should they. A nursing note for Resident 73, dat yelling out. His brother phoned the medication due to his yelling out ar A nursing note for Resident 73, dat calming medications. A nursing note for Resident 73, dat believed the facility was over-medir regarding her brother making decis A nursing note for Resident 73, dat (vomiting) medication for calming, to	ted August 28, 2022, revealed that he resoda was placed in the refrigerator for ook my pop. ted September 6, 2022, revealed that he was aware he was not supposed to hat ted September 15, 2022, revealed that ted October 15, 2022, revealed that he have regular soda and he was angry and ted October 9, 2022, revealed that he nourses and requested that Resident 73 and having behaviors. ted October 10, 2022, revealed that his cating the resident and that he was seed sions regarding Resident 73's care. ted October 19, 2022, revealed that he to be administered once every eight ho ted October 26, 2022, revealed that he to be ded October 26, 2022, revealed that he to be ded October 26, 2022, revealed that he to be ded October 26, 2022, revealed that he	would try to come in. sister told nursing staff that she and d, and she would like his diet and the family should not bring nursing staff phoned his sister to shaviors. sister phoned and again requested foods. She was informed he would She was educated that he required eturned from a doctor appointment later use. Later that evening the is sister was observed feeding him we it. his sister was in to visit and left him continuously yelled and demanded and stated that his sisters gave him eturned from the hospital and was a be medicated with calming sister did not want him to have sister was upset because she lated. She expressed anger was ordered an anti-emetic urs if needed.

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 12/07/2022
NAME OF PROVIDER OR SUPPLII	ED.	CTREET ADDRESS SITV STATE ZID SODE	
Twin Lakes Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZI 227 Sand Hill Road	PCODE
I WIII Lakes Reliabilitation and Healthcare Center		Greensburg, PA 15601	
For information on the nursing home's	plan to correct this deficiency, please con	tact 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 0607 Level of Harm - Minimal harm or potential for actual harm	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.		
Residents Affected - Some			
		ed November 16, 2022, revealed that viors and that they did not want him se	
	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 Behavio	or and Facility Practices, 10-1-1998 edi	tion.
	28 Pa. Code 201.14(c) Responsibil	lity of licensee.	
	28 Pa. Code 201.18(e)(1) Manager	ment.	
	28 Pa. Code 211.12(d)(5) Nursing	services.	
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395500	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/07/2022
NAME OF PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZI	D CODE
Twin Lakes Rehabilitation and Hea			PCODE
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 con	tact 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)		on)
F 0609	Timely report suspected abuse, ne authorities.	glect, or theft and report the results of t	he investigation to proper
Level of Harm - Minimal harm or potential for actual harm	38012		
Residents Affected - Some	interviews, it was determined that t	clinical records, and facility investigation he facility failed to ensure that staff report two of 47 residents reviewed (Residents)	orted an allegation of physical or
	Findings include:		
		e, dated February 17, 2022, indicated to s to immediately report the suspicion to 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.		
	cognitively intact, required extensive placed into the stomach for nutrition included cerebral palsy (injury at bits).	esident 73, dated August 11, 2022, ind re assistance from staff for care, had a n), had behaviors such as verbal aggre rth that causes difficulty with movemen ce (memory loss), and dysphagia (swa	feeding tube (a tube surgically ssion, and had diagnoses that it, muscle tone and posture),
	mother and brother separated and mother would never hurt his brothe that her having dementia would alto stated that Resident 73 was independently going out to eat at restauration was intubated and ended up with a but because of his intellectual disal	on December 6, 2022, at 1:45 p.m. reine felt that they should remain in the sar. He said that he knew that his mother er her thought process or her ability to dendent, enjoyed going for walks, was so ants. In December 2021 Resident 73 go feeding tube as well. He said that Respolities, Resident 73 does not understar to out to eat or just walk around anymor	ame room. He stated that his had dementia, but he did not think deal with stressful situations. He ocial in his neighborhood, and ot COVID and became very ill. He ident 73 deteriorated significantly had what has happened to him or
	(continued on next page)		

			NO. 0936-0391
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 12/07/2022
NAME OF PROVIDER OR SUPPLIER Twin Lakes Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZI 227 Sand Hill Road Greensburg, PA 15601	P CODE
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	CIENCIES full regulatory or LSC identifying informati	on)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A nursing note for Resident 73, dat as yelling out. A nursing note, date threatening staff saying that he did they did sexual things to him. Staff names. A nursing note for Resident 71, dat room away from Resident 73 (her sexual things to him. Staff names. A nursing note for Resident 73, dat determined that he was not safe to sister stated that she understood be a nursing note for Resident 73, dat regardless of his risk of aspiration (her sexual thing). A nursing note, dated May 6, 2022 at him, which increased his behavious antagonizing Resident 73 whe trouble. She was very argumentative A nursing note for Resident 73, dat Resident 71 yell shut up you retard A nursing note for Resident 73, dat and redirection and medication were A nursing note for Resident 73, dat and was not able to be redirected. A nursing note for Resident 73, dat him, and that Resident 71 was four physician's order to not give him and A nursing note, dated May 12, 2021 and that despite the nurse's efforts telling Resident 73 to shut up, shut you. When asked what she needed 73 I hate you, you're just a waste of A social service note for Resident 73 family meeting to discuss his behave.	ted April 18, 2022, revealed that he had d April 21, 2022, revealed that Resident not like anyone there and would get the were unable to calm him as he yelled, and a pril 19, 2022, revealed that she did son), despite the yelling and arguing be seed April 25, 2022, revealed that he was eat foods and that he would continue the still wanted him to have food. The deed May 1, 2022, revealed that his famility (choking on the food). The revealed that Resident 73 was yelling fors. A nursing note for Resident 71, dath was quiet and was heard saying prove with caretakers. The deed May 6, 2022, revealed that he was go at him. The deed May 7, 2022, revealed that he screate ineffective. The deed May 8, 2022, at 3:58 a.m. revealed Other residents were upset and mad the sed May 8, 2022, at 10:01 a.m. revealed Other residents were upset and mad the sed May 8, 2022, at 10:01 a.m. revealed of the did giving him drinks of water, despite him the did giving him drinks of water, despite him the sed of the hell up, these people hate you and did, Resident 71 stated him to shut the helf time, shut the hell up you idiot.	It displayed verbal behaviors such at 73 was yelling out and em all in serious trouble by saying and he began to call the staff. It do not want to be moved to another stween them. It is evaluated by speech therapy and to require the feeding tube. His the require the feeding tube. His the poiss your pants, that will get them in the poiss your pants, the poiss your pants, the poiss your pants, the poiss your pants, the poiss your pants the poiss your pants, the poiss your pants the pants the poiss your pants the pants the poiss your pants the pants t
	(continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 395500 NAME OF PROVIDER OR SUPPLIER Twin Lakes Rehabilitation and Healthcare Center (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURV. COMPLETED 12/07/2022 STREET ADDRESS, CITY, STATE, ZIP CODE 227 Sand Hill Road Greensburg, PA 15601	VEY	
Twin Lakes Rehabilitation and Healthcare Center 227 Sand Hill Road		
Twin Lakes Rehabilitation and Healthcare Center 227 Sand Hill Road		
	227 Sand Hill Road	
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 0609 A nursing note for Resident 73, dated May 18, 2022, revealed that the nurse practitioner recommedication changes and discussed this with his sister. However, on May 19, 2022, his sister not want any medication changes and wanted the medication discontinued. A nursing note for Resident 73, dated May 21, 2022, revealed that the nurse practitioner recommedication changes and wanted the medication discontinued. A nursing note for Resident 73, dated May 21, 2022, revealed that the nurse practitioner recommedication changes and wanted the medication discontinued.	decided she did	
Residents Affected - Some screamed out all shift and was not able to be redirected. He continued to yell out all shift and comments that his mother masturbated him and that he would say staff touched him sexually in trouble. He could not be redirected.	began to make	
A nursing note for Resident 73, dated May 24, 2022, revealed that he continuously yelled throand that he was not able to be consoled. He yelled at staff and called them names and yelled as well.		
A nursing note for Resident 73, dated June 1, 2022, revealed that he continuously yelled out attention seeking behaviors. Resident 71 was overheard yelling shut up you retard to Resident aggravated him more. When the nurse attempted to educate Resident 71 that she should not retard, she replied, I call them like I see them.	nt 73, which	
A nursing note for Resident 71, dated June 16, 2022, revealed that she was having an increa and was trying to pull Resident 73 out of bed. She was confused and not easily redirected. St 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 staff and that numerous attempts to calm him were unsuccessful. At 8:15 p.m. the nurse char resident could not be consoled and was continuing to yell and scream so much that he was s profusely. He was given one-on-one attention and care and he continued to scream. The fam medication for behaviors.	rted that the sweating	
A nursing note for Resident 71, dated July 4, 2022, revealed that she was complaining of har and was found to have slight bruising and swelling to the left hand and wrist. The licensed president 71 slap Resident 73 across the face.		
A nursing note for Resident 71, dated July 5, 2022, revealed that the licensed practical nurse did not see her slap Resident 73, but she heard a slap sound and heard the resident say ouc		
A nursing note for Resident 73, dated July 17, 2022, revealed that his family was feeding him not pureed, which was his ordered consistency.	n food that was	
A nursing note for Resident 71, dated July 26, 2022, revealed that she was cursing and yelling at Resident 73 to shut up and called him stupid.	ng at staff and	
A nursing note for Resident 73, dated July 31, 2022, revealed that he was demanding care from the was wet or soiled; however, when care was provided, he would be dry, and he would yell 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 obscenition other residents, unable to be calmed.	es and upsetting	
(continued on next page)		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN OF CORRECTION	395500	A. Building	12/07/2022
	39300	B. Wing	12/01/2022
NAME OF PROVIDER OR SUPPLIE	NAME OF PROVIDER OR SUPPLIER		P 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 con	tact 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 informati	on)
F 0609	A nursing note for Resident 73, dat	ted August 11, 2022, revealed that he v	vas found to have cookies that
Level of Harm - Minimal harm or		moved them for his safety he yelled and and fed him the cookie to try to calm hir	
potential for actual harm	and scream.	and red min the social to try to cam in	n, newever, ne continued to you
Residents Affected - Some		t 73, dated August 14, 2022, revealed t	hat he was yelling out and
	Resident 71 called him crazy and to	old him to shut up.	
		ted August 16, 2022, revealed that he valled for assistance, and they stated they	
		ted August 19, 2022, revealed that his s	
		regular consistency food in, not pureed educated that he is at risk of aspiration	
	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.		
		ted August 28, 2022, revealed that he r soda was placed in the refrigerator for ook my pop.	
		ted September 6, 2022, revealed that h was aware he was not supposed to ha	
	A nursing note for Resident 73, dat with regular pop in his room.	ted September 15, 2022, revealed that	his sister was in to visit and left him
	,	ted October 15, 2022, revealed that he have regular soda and he was angry an	, ,
	A nursing note for Resident 73, dated October 9, 2022, revealed that he returned from the hospital and w 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, dat calming medications.	ted October 10, 2022, revealed that his	sister did not want him to have
	(continued on next page)		

			NO. 0930-0391
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 12/07/2022
NAME OF PROVIDER OR SUPPLIE Twin Lakes Rehabilitation and Hea			IP CODE
For information on the nursing home's	plan to correct this deficiency, please con		agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	CIENCIES full regulatory or LSC identifying informat	ion)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	believed the facility was over-media regarding her brother making decise. A nursing note for Resident 73, dat (vomiting) medication for calming, the A nursing note for Resident 73, dat threatened to put a gun to their head threatened to put a gun to their head a nursing note for Resident 73, dat she placed her hands on his face a face away. A nursing note for Resident 73, dat 73 moved out of his current room the about having a one-on-one come in want a room move or to have Resident 73 could be medicated for his behad A nursing note for Resident 73, dat 73 could be medicated for his behad A nursing note for Resident 73, dat that he and his mother continued to was present, and they continued to There was no documented evidence abuse for Resident 71 or Resident Interview with the Nursing Home As should report any allegation/observinvestigate and report it timely. She 71 and Resident 73, but that she did	ed October 19, 2022, revealed that he obe administered once every eight hold be administered once every eight hold and blow their brains out. ed November 10, 2022, revealed that he ad and said, Shut up or I will claw your f*cl ed November 11, 2022, revealed that hat he shared with Resident 71. He stanto the building. Resident 73's sister that the shared with Resident 73's sister that the shared with Resident 73's sister that the shared with Resident 71. He stanto the building. Resident 73's sister that the November 16, 2022, revealed that haviors and that they did not want him so ed December 2, 2022, revealed that he over the each other, and they could not a yell. The that the Department of Health was resident 73. In diministrator on December 6, 2022 at 1 and the stated that they did report one incidered not report any others because she did not report any others because she did read and Facility Practices, 10-1-1998 edicity of licensee.	was ordered an anti-emetic burs if needed. called staff derogatory names and the was yelling at Resident 71 when king eyes out. She then pushed his his brother did not want Resident ated that he would talk to his family ten phoned and stated she did not this siblings all agreed that Resident eparated from Resident 71. The had an increase in behaviors and the redirected. Resident 73's sister to intified about the allegations of 2:00 p.m. confirmed that staff the administrative staff are to int that occurred between Resident lid not feel it was abuse.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395500	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/07/2022	
		b. wing		
NAME OF PROVIDER OR SUPPLIE	NAME OF PROVIDER OR SUPPLIER		P CODE	
Twin Lakes Rehabilitation and Hea	ation and Healthcare Center 227 Sand Hill Road Greensburg, PA 15601			
For information on the nursing home's	plan to correct this deficiency, please con	tact 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)		on)	
F 0610	Respond appropriately to all allege	d violations.		
Level of Harm - Minimal harm or potential for actual harm	38012			
Residents Affected - Some		nical records, as well as staff interviews gation into the abuse between two resi		
	Findings include:			
		e and neglect, dated February 17, 2022 eglect and abuse were thoroughly inves		
	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.			
	cognitively intact, required extensiv placed into the stomach for nutrition included cerebral palsy (injury at bi	esment for Resident 73, dated August 11, 2022, indicated that the resident was red extensive assistance from staff for care, had a feeding tube (a tube surgically h for nutrition), had behaviors such as verbal aggression, and had diagnoses that a (injury at birth that causes difficulty with movement, muscle tone and posture), ral disturbance (memory loss), and dysphagia (swallowing difficulties).		
	mother and brother separated and mother would never hurt his brothe that her having dementia would alto stated that Resident 73 was independently going out to eat at restauration was intubated and ended up with a but because of his intellectual disal	ily Member 1 on December 6, 2022, at 1:45 p.m. revealed that he did not want his parated and he felt that they should remain in the same room. He stated that his urt his brother. He said that he knew that his mother had dementia, but he did not the tid would alter her thought process or her ability to deal with stressful situations. He 3 was independent, enjoyed going for walks, was social in his neighborhood, and at at restaurants. In December 2021 Resident 73 got COVID and became very ill. I ded up with a feeding tube as well. He said that Resident 73 deteriorated significant ellectual disabilities, Resident 73 does not understand what has happened to him o o home or go out to eat or just walk around anymore.		
	(continued on next page)			

			NO. 0936-0391
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 12/07/2022
NAME OF PROVIDER OR SUPPLIER Twin Lakes Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZI 227 Sand Hill Road Greensburg, PA 15601	P CODE
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by	CIENCIES full regulatory or LSC identifying informati	on)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A nursing note for Resident 73, dat as yelling out. A nursing note, date threatening staff saying that he did they did sexual things to him. Staff names. A nursing note for Resident 71, dat room away from Resident 73 (her see A nursing note for Resident 73, dat determined that he was not safe to sister stated that she understood be A nursing note for Resident 73, dat regardless of his risk of aspiration (A nursing note, dated May 6, 2022 at him, which increased his behavious was antagonizing Resident 73 whe trouble. She was very argumentative A nursing note for Resident 73, dat Resident 71 yell shut up you retard A nursing note for Resident 73, dat and redirection and medication were A nursing note for Resident 73, dat and was not able to be redirected. A nursing note for Resident 73, dat him, and that Resident 71 was four physician's order to not give him ar A nursing note, dated May 12, 202 and that despite the nurse's efforts telling Resident 73 to shut up, shut you. When asked what she needed 73 I hate you, you're just a waste of A social service note for Resident 73 siblings. An individual caregiver was siblings.	full regulatory or LSC identifying information and April 21, 2022, revealed that he had a April 21, 2022, revealed that Residen not like anyone there and would get the were unable to calm him as he yelled, and April 19, 2022, revealed that she did son), despite the yelling and arguing be seed April 25, 2022, revealed that he was eat foods and that he would continue that still wanted him to have food. The ded May 1, 2022, revealed that his family (choking on the food). The revealed that Resident 73 was yelling fors. A nursing note for Resident 71, dat and he was quiet and was heard saying prove with caretakers. The ded May 6, 2022, revealed that he was a lat him. The ded May 7, 2022, revealed that he screamed may 1, 2022, at 3:58 a.m. revealed. Other residents were upset and mad the seed May 8, 2022, at 10:01 a.m. revealed. Other residents were upset and mad the seed May 8, 2022, at 10:01 a.m. revealed and giving him drinks of water, despite him the left of the lup, these people hate you and the Resident 73 that the hell up, these people hate you and the Resident 71 stated him to shut the hell fitme, shut the hell up you idiot. The ded May 17, 2022, revealed that a series of the hell up, the series of the hell up, these people hate you and the fitme, shut the hell up you idiot. The ded May 17, 2022, revealed that a series of the family, and they are recommended to the family.	It displayed verbal behaviors such at 73 was yelling out and em all in serious trouble by saying and he began to call the staff. It do not want to be moved to another stween them. It is evaluated by speech therapy and to require the feeding tube. His the require the feeding tube. His the poiss your pants, that will get them in the poiss your pants, the poiss your pants, the poiss your pants, the poiss your pants, the poiss your pants the poiss your pants, the poiss your pants the pants the poiss your pants the pants the poiss your pants the pants t
	(continued on next page)	ate the social worker regarding a one-o	n-one care intervention.

			No. 0936-0391
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 12/07/2022
	NAME OF PROVIDER OR SUPPLIER Twin Lakes Rehabilitation and Healthcare Center		P CODE
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	CIENCIES full regulatory or LSC identifying informati	ion)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A nursing note for Resident 73, dat medication changes and discussed not want any medication changes at A nursing note for Resident 73, dat screamed out all shift and was not comments that his mother masturb in trouble. He could not be redirect. A nursing note for Resident 73, dat and that he was not able to be consas well. A nursing note for Resident 73, dat attention seeking behaviors. Resident gravated him more. When the nuretard, she replied, I call them like I and was trying to pull Resident 73, dat staff and that numerous attempts to resident could not be consoled and profusely. He was given one-on-on medication for behaviors. A nursing note for Resident 71, dat and was found to have slight bruisi stated that she observed Resident 74, dat did not see her slap Resident 73, dat not pureed, which was his ordered. A nursing note for Resident 71, dat yelling at Resident 73 to shut up ar A nursing note for Resident 73, dat he was wet or soiled; however, who call them swear words. He also contains the summer of the serious profusers who call them swear words. He also contains the summer of the serious profusers and the seriou	and May 18, 2022, revealed that the number of this with his sister. However, on May and wanted the medication discontinue and wanted him and that he would say staff to attend him and that he would say staff to attend the property of the control	rse practitioner recommended 19, 2022, his sister decided she did d. s very agitated and continually yell out all shift and began to make suched him sexually to get everyone dinuously yelled throughout the shift in names and yelled at Resident 71 dinuously yelled out and had ou retard to Resident 73, which that she should not call him a as having an increase in behaviors easily redirected. Staff phoned her d increased yelling outbursts at p.m. the nurse charted that the much that he was sweating to scream. The family refused s complaining of hand and wrist pain ist. The licensed practical nurse ased practical nurse now stated she he resident say ouch. hilly was feeding him food that was as cursing and yelling at staff and s demanding care from staff stating the resident say out and he would yell at the staff and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
, , , , , , , , , , , , , , , , , , ,	395500	A. Building	12/07/2022
	000000	B. Wing	
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZI	P 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 con	tact 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 informati	on)
F 0610	A nursing note for Resident 73, dat	red August 11, 2022, revealed that he v	vas found to have cookies that
Level of Harm - Minimal harm or		moved them for his safety he yelled and and fed him the cookie to try to calm hir	
potential for actual harm	and scream.		, , , .
Residents Affected - Some	A social service's note for Resident Resident 71 called him crazy and to	t 73, dated August 14, 2022, revealed t old him to shut up.	hat he was yelling out and
		ted August 16, 2022, revealed that he valily for assistance, and they stated they	
	A nursing note for Resident 73, dated August 19, 2022, revealed that his sister told nursing staff that she ar 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.		
		ed August 22, 2022, revealed that the changes to help with his anxiety and be	
	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 require 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.		
		ted September 6, 2022, revealed that h was aware he was not supposed to ha	
	A nursing note for Resident 73, dat with regular pop in his room.	ted September 15, 2022, revealed that	his sister was in to visit and left him
	,	ed October 15, 2022, revealed that he have regular soda and he was angry a	, ,
	A nursing note for Resident 73, dated October 9, 2022, revealed that he returned from the hospital and w 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, dat calming medications.	ed October 10, 2022, revealed that his	sister did not want him to have
	(continued on next page)		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395500	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/07/2022
		b. wing	
NAME OF PROVIDER OR SUPPLIE	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE		P CODE
Twin Lakes Rehabilitation and Hea	althcare Center	227 Sand Hill Road Greensburg, PA 15601	
For information on the nursing home's	plan to correct this deficiency, please con	tact 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)		on)
F 0610 Level of Harm - Minimal harm or potential for actual harm		ted October 17, 2022, revealed that his cating the resident and that he was sec sions regarding Resident 73's care.	
Residents Affected - Some		ted October 19, 2022, revealed that he to be administered once every eight ho	
	A nursing note for Resident 73, dat threatened to put a gun to their hea	ted October 26, 2022, revealed that he and blow their brains out.	called staff derogatory names and
	,	ted November 10, 2022, revealed that had said, Shut up or I will claw your f*ck	, ,
	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 famil 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.		ted that he would talk to his family
		ted November 16, 2022, revealed that haviors and that they did not want him se	
	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.		
	at each other and that she tries to state are family members that visit said the family instigates the reside	ide 4 on December 5, 2022, at 3:48 p.m. revealed that Residents 71 and 73 often she tries to separate them; however, they do not like to leave their room. She saiders that visit, but they are not able to get them to stop yelling at each other either. East he residents by bringing food and drink items in for Resident 73 that he cannot pureed diet with thickened liquids, then Resident 73 gets angry when staff have to esident 71 yells at them all. Idde 5 on December 5, 2022, at 3:52 p.m. revealed that Resident 71 and Resident other, and the staff are not able to redirect them. She stated that Resident 73 gets yells at him and then he yells more. She said Resident 71 yells at Resident 73 and	
	constantly yell at each other, and the		
	and that Resident 71 yells and swe aide came to get her because the r telling him to shut up and calling hi	on December 5, 2022, at 4:17 p.m. revolutes at him to shut up and calls him nar nurse aide witnessed Resident 71 with m names. She said she wanted to separanother, but administration told her she	nes. She said that recently a nurse her hands on Resident 73's neck arate the residents since they room
	(continued on next page)		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395500	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/07/2022
NAME OF PROVIDED OR SUPPLIE	-n	CTREET ADDRESS CITY STATE 7	D CODE
NAME OF PROVIDER OR SUPPLIER Twin Lakes Rehabilitation and Healthcare Center 227 Sand Hill Road		PCODE	
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 con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by	CIENCIES full regulatory or LSC identifying informati	on)
F 0610		e that administration conducted thoround physical abuse between Resident	
Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some		dministrator on December 6, 2022 at 1 orts of verbal and physical abuse betw	
Nosidents Anected - Some	42 CFR 483.13 - Resident Behavio	r and Facility Practices, 10-1-1998 edi	tion.
	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) Administrato	r's responsibility.	
	28 Pa. Code 211.12(d)(3) Nursing	services.	
	28 Pa. Code 211.12(d)(5) Nursing	services.	
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
, , , , , , , , , , , , , , , , , , ,	395500	A. Building	12/07/2022
		B. Wing	
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZI	P CODE
Twin Lakes Rehabilitation and Hea	win 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 con	tact 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)		on)
F 0742		and services to a resident who displays	
Level of Harm - Actual harm	disorder.	•	•
Residents Affected - Few	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).		oral health care and services for
	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 pow of attorney or legal guardian.		s the mother of Resident 73.
	needs) for Resident 71, dated Nov assistance from staff for daily care others, and had diagnoses that inc	parata Set (MDS) assessment (a mandated assessment of a resident's abilities and care, dated November 12, 2022, indicated that the resident was cognitively intact, required or daily care needs, had behaviors such as physical and verbal aggression towards uses that included dementia. Resident 71's care plan for verbal and aggressive dident 73, dated May 24, 2022, indicated that staff would monitor her aggressive.	
	cognitively intact, required extensive placed into the stomach for nutrition included cerebral palsy (injury at bits)	ment for Resident 73, dated August 11, 2022, indicated that the resident was ed extensive assistance from staff for care, had a feeding tube (a tube surgically for nutrition), had behaviors such as verbal aggression, and had diagnoses that injury at birth that causes difficulty with movement, muscle tone and posture), all disturbance (memory loss), and dysphagia (swallowing difficulties). Member 1 on December 6, 2022, at 1:45 p.m. revealed that he did not want his arated and he felt that they should remain in the same room. He stated that his is his brother. He said that he knew that his mother had dementia, but he did not thir a would alter her thought process or her ability to deal with stressful situations. He was independent, enjoyed going for walks, was social in his neighborhood, and at restaurants. In December 2021 Resident 73 got COVID and became very ill. He d up with a feeding tube as well. He said that Resident 73 deteriorated significantly ectual disabilities, Resident 73 does not understand what has happened to him or home or go out to eat or just walk around anymore.	
	mother and brother separated and mother would never hurt his brothe that her having dementia would alt stated that Resident 73 was independently going out to eat at restaurated was intubated and ended up with a but because of his intellectual disal		
	as yelling out. A nursing note dated staff saying that he did not like any	t 73, dated April 18, 2022, revealed that he had displayed verbal behaviors such te dated April 21, 2022, revealed that Resident 73 was yelling out and threatenir like anyone there and would get them all in serious trouble by saying they did were unable to calm him as he yelled, and he began to call the staff names.	
	(continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (XI) DENTIFICATION NUMBER: 305500 NAME OF PROVIDER OR SUPPLIER Twin Lakes Rehabilitation and Healthcare Center STREET ADDRESS, CITY, STATE, ZIP CODE 227 Sand Hill Road Greenaburg, PA 15801 For information on the nursing homes's plan to correct this deficiency, please contact the nursing home or the state survey agency. [XXI] ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) F 0742 An urusing note for Resident 71, dated April 19, 2022, revealed that she did not want to be moved to another room away from Resident 71, dated April 19, 2022, revealed that she 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 the understood but still warted him in 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 despiration (cholding on the food). A nursing note for Resident 73, dated May 1, 2022, revealed that he was yelling out and Resident 71 began yelling at him, which increased his behaviors. A nursing note for Resident 73 dated May 6, 2022, revealed that he was yelling out and Resident 71 began yelling at him, which increased his behaviors. A nursing note for Resident 73 dated May 6, 2022, revealed that he was yelling out and Resident 71 began yelling at him, which increased his behaviors. A nursing note for Resident 73 dated May 6, 2022, revealed that he was yelling out and Resident 71 began yelling out and redirection and machine he was quited and was heard saying pies your parts, that will get them in trouble. She was very argumentative with caretakers. A nursing note for Resident 73, dated May 8, 2022, revealed that he was yelling out and the nurse heard redirection and medication were ineffective. A nursing note for Resident 73, dated May 8, 2022, 2, 2, 2, 2, 2, 2, 2, 2, 2, 2, 2, 2,					
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. SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) A nursing note for Resident 73, dated April 25, 2022, revealed that she did not want to be moved to another room away from Resident 73, dated April 25, 2022, revealed that he was evaluated by speech therapy and determined that he was not safe to eat fnocts 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 73 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 vas yelling out and the nurse heard Resident 71 yell shut up you retard at him. A nursing note for Resident 73, dated May 8, 2022, at 10.01 a.m. revealed that he was metabout to 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 mediated to calm him, and that Resident 71 was found from first of water, despite his inability to sedicated to calm him, and that Resident 73 was become from the following resident 73 has you, you're just a waste of firms, shut the hell up, these people hate you and		IDENTIFICATION NUMBER:	A. Building	COMPLETED	
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. SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) A nursing note for Resident 73, dated April 25, 2022, revealed that she did not want to be moved to another room away from Resident 73, dated April 25, 2022, revealed that he was evaluated by speech therapy and determined that he was not safe to eat fnocts 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 73 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 vas yelling out and the nurse heard Resident 71 yell shut up you retard at him. A nursing note for Resident 73, dated May 8, 2022, at 10.01 a.m. revealed that he was metabout to 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 mediated to calm him, and that Resident 71 was found from first of water, despite his inability to sedicated to calm him, and that Resident 73 was become from the following resident 73 has you, you're just a waste of firms, shut the hell up, these people hate you and	NAME OF PROVIDED OR SUPPLU		STREET ANDRESS CITY STATE 71	P CODE	
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. SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) 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 19, 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 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 for Resident 73 was yelling out and Resident 71 began yelling at him, which increased his behaviors. 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 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 was yelling out and the nurse heard Resident 73 and refrective on and medication were ineffective. A nursing note for Resident 73, dated May 8, 2022, at 10:01 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 to up you with manything by mouth. A nursi				F CODE	
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			NO. 0936-0391
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 12/07/2022
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 con	tact 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	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, dat other residents, unable to be calmed	ed August 8, 2022, revealed that he wared.	as yelling obscenities and upsetting
	(continued on next page)		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395500	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/07/2022
NAME OF PROVIDER OR SUPPLI	ER	STREET ADDRESS, CITY, STATE, ZI	P 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 con	tact 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	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 Resident 71 called him crazy and t	t 73, dated August 14, 2022, revealed t old him to shut up.	hat he was yelling out and
	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 in that evening the resident fell while screaming they took my pop.		
		ted September 6, 2022, revealed that h was aware he was not supposed to ha	
	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 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.		
		ted October 15, 2022, revealed that he have regular soda and he was angry a	
	(continued on next page)		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. Building	(X3) DATE SURVEY COMPLETED	
	395500	B. Wing	12/07/2022	
NAME OF PROVIDER OR SUPPLII	ER	STREET ADDRESS, CITY, STATE, ZI	P CODE	
Twin Lakes Rehabilitation and Hea	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 con	tact 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	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.			
Residents Affected - Few		red October 19, 2022, revealed that he	was ordered an anti-emetic	
reducino rincoled i ew		to be administered once every eight ho		
	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.			
	November 6, 2022, seven months interventions since that time. There	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: 395500	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/07/2022
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 con	Lact 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 angry that Resident 71 yells at him calls him names. Interview with Registered Nurse 6 and that Resident 71 yells and swe aide came to get her because the retelling him to shut up and calling him.	ne staff are not able to redirect them. So and then he yells more. She said Reson December 5, 2022, at 4:17 p.m. revears at him to shut up and calls him nanurse aide witnessed Resident 71 with m names. She said she wanted to sep another, but administration told her shutty of licensee.	She stated that Resident 73 gets ident 71 yells at Resident 73 and realed that Resident 73 yells a lot mes. She said that recently a nurse her hands on Resident 73's neck arate the residents since they room