STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Twin Lakes Rehabilitation and Healthcare Center	227 Sand Hill Road Greensburg, PA 15601

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 42079 Based on clinical record reviews, observations, and staff interviews, it was determined that the facility failed to care for each resident in a manner that maintained dignity during dining for one of 48 residents reviewed (Resident 18). Findings include: A Quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 18, dated November 4, 2021, revealed that the resident was cognitively intact, required extensive assistance from staff for daily care, and was frequently incontinent of bowel and bladder. An incontinence care plan for Resident 18, revised on February 11, 2021, revealed that the resident had urinary incontinence and that incontinence care should be provided as needed. Observations during the lunch meal on January 9, 2022, at 12:55 p.m. revealed that Temporary Nurse Aide 17 was collecting Resident 18's tray in the room. Resident 18 indicated that her brief was soiled and she needed assistance. Temporary Nurse Aide 17 stated they would return after lunch trays were collected. Interview with Temporary Nurse Aide 17 on January 9, 2022, at 1:12 p.m. confirmed that Resident 18's brief needed changed and that she was told not to assist with care until after the lunch cart was off the floor. Resident 18 was not provided care until 1:13 p.m. Interview with the Director of Nursing on January, 12, 2022, at 11:34 a.m. confirmed that staff should assist with incontinence care when they were made aware of the need for assistance, regardless of meal times and trays delivery. 28 Pa. Code 201.29(j) Resident rights.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 38012 Based on review of policies and personnel files, as well as staff interviews, it was determined that the facility failed to complete nurse aide license checks prior to hire for two of three nurse aides reviewed and failed to complete registered nurse license checks prior to hire for two of two registered nurses reviewed (Employees 1, 2, 3, 4). Findings include: The facility's Abuse policy, dated December 29, 2021, indicated that the facility would not employ individuals who had a finding entered in the state nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property, or individuals that had a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. The personnel file for Employee 1 revealed that she was hired as a nurse aide on November 1, 2021, and the Pennsylvania Nurse Aide Registry check was verified on January 10, 2022, two months after she was hired. The personnel file for Employee 2 revealed that she was hired as a nurse aide on September 30, 2021, and the Pennsylvania Nurse Aide Registry check was verified on October 11, 2021, 12 days after she was hired. The personnel file for Employee 3 revealed that she was hired as a registered nurse on December 10, 2021, and the Pennsylvania Professional Licensure check was not verified until January 11, 2022, one month after she was hired. The personnel file for Employee 4 revealed that she was hired as a registered nurse on December 16, 2021, and the Pennsylvania Professional Licensure check was not verified until January 11, 2022, one month after she was hired. Interview with the Nursing Home Administrator on January 12, 2022, at 9:30 a.m. confirmed that there was no documented evidence that Employees 1 and 2's standing on the Pennsylvania Nurse Aide Registry was verified prior to their hire, or that Employees 3 and 4's standing on the Pennsylvania Professional Licensure Registry was verified prior to their hire date. 28 Pa. Code 201.18(e)(1) Management.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition 31760 Based on review of the Resident Assessment Instrument User's Manual and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that comprehensive significant change Minimum Data Set assessments were completed in the required time frame for one of 46 residents reviewed (Resident 48). Findings include: The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, which provides instructions and guidelines for completing required Minimum Data Set (MDS) assessments (mandated assessments of a resident's abilities and care needs), dated October 2019, indicated that the Assessment Reference Date (ARD) was to be no later than the 14th calendar day after determination that a significant change in the resident's status occurred (determination date + 14 calendar days) and the significant change comprehensive MDS assessment was to be completed no later than the 14th calendar day after determination that significant a change in the resident's status occurred (determination date + 14 calendar days). A care plan for Resident 48, dated November 18, 2021, revealed that the resident required hospice care (medical care to help someone with a terminal illness) due to a diagnosis of dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life). Physician's orders for Resident 48, dated November 18, 2021, included an order for the resident to be admitted to hospice. A significant change in status MDS assessment for Resident 48 with an ARD date of December 7, 2021, was 20 days after the determination date and signed off as being completed December 9, 2021, which was 22 days after the determination date. Interview with Registered Nurse Assessment Coordinator (RNAC - a registered nurse who is responsible for completing MDS assessments) on January 11, 2022, at 1:18 p.m. revealed that they had entered the wrong date for the ARD and confirmed that the significant change comprehensive MDS assessment for Resident 48 was not completed within the required time frame. 28 Pa. Code 211.5(f) Clinical records.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 31760 Based on review of clinical records, as well as staff interviews, it was determined that the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice, by failing to adequately monitor residents' bowel function and to ensure that physician's orders for bowel protocols were followed, which resulted in the resident being hospitalized with fecal impaction requiring medical intervention for one of 46 residents reviewed (Resident 41), and by failing to follow physician's orders for obtaining temperatures for one of 46 residents reviewed (Resident 31). Findings include: A quarterly MDS assessment for Resident 41, dated November 24, 2021, revealed that the resident was cognitively impaired, required staff assistance for toileting, and was always incontinent of bowel. Physician's orders dated October 10, 2015, included an order for the resident to receive 30 milliters (ml) of Milk of Magnesia (an oral laxative for constipation) as needed every 24 hours to be given on the 7:00 a.m. to 3:00 p. m. shift if there was no bowel movement in three days, a Bisacodyl suppository (a laxative inserted rectally) as needed every 24 hours to be given on the 3:00 p.m. to 11:00 p.m. shift if the Milk of Magnesia was ineffective, and a Fleets enema (a liquid inserted rectally to stimulate a bowel movement) every 24 hours as needed if there was no bowel movement by the end of the following shift after administration of suppository, and to notify the physician if ineffective. Resident 41's bowel records for December 2021 revealed that she did not have a bowel movement from December 11-19, 2021, (9 days) and December 21-24 (4 days), and the resident's Medication Administration Record (MAR) for those dates revealed that Milk of Magnesia was administered on December 9, 2021; however, its efficacy was unknown and there was no suppository or fleets enema administered. Milk of Magnesia was administered on December 14 with an E for effective; however, there was no documented bowel movement in the resident's clinical record. There was no Milk of Magnesia administered between December 21-31, 2021; however, a suppository was administered on December 27 and was I ineffective and an enema was administered on December 27 and was I ineffective. A nursing note for Resident 41, dated December 27, 2021, indicated that her abdomen was very distended and that the registered nurse was made aware. A nursing note, dated December 28, 2021, indicated that she had complaints of abdominal pain, abdomen was distended and there were no bowel sounds present, and the registered nurse was notified. A nursing note, dated December 28, 2021, indicated that the resident had an x-ray of her abdomen and that there was some dilation of the large and small bowel loops (stretching) and possible fecal obstruction in the rectum. A nursing note, dated December 29, 2021, indicated that the resident continued to have a distended abdomen, medication administered was ineffective, and that staff will continue to monitor. A nursing note, dated December 29, 2021, indicated that the resident had another abdominal x-ray and that she had an ileus (blocked intestine and bowel movement is not able to move through this area) and that a nasogastric tube (NG tube - a tube inserted through the nose and into the stomach so that stomach and intestine contents can be pulled out because they will not pass through the intestines due to a block) was inserted. The resident was transferred to the hospital at that time and admitted with fecal impaction. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	emergency room records for Resident 41, dated December 29, 2021, indicated that the resident had grossly impacted rectal and distal sigmoid colonic fecal matter. Hospital records, dated December 30, 2021, indicated that Resident 41 had an NG tube placed and that she had air-filled dilated colonic and small bowel loops, distal colonic stool retention was significant. Hospital records for Resident 41, dated January 3, 2022, indicated that the resident had over two liters of bilious fluid (bile) taken out through the NG tube in 24 hours and that the physician performed manual disimpaction of stool at bedside with a large amount of solid stool coming out. She continued to receive enemas and had several more large bowel movements. Hospital records for Resident 41, dated January 4, 2022, indicated that she was diagnosed with chronic constipation and stercoral proctitis (stercoral proctitis is a rare life-threatening inflammatory process involving the rectal wall secondary to chronic constipation and fecal impaction). Interview with the Director of Nursing on January 12, 2022, confirmed that Resident 41's physician's orders for bowel medications were not followed and they should have been and that there was no documented registered nurse assessment of Resident 41 from December 11 through December 29 and that there should have been. Physician's orders for Resident 31, dated January 7, 2022, included an order for staff to check the resident's temperature every day and evening shift and to notify the physician if the temperature was greater than 99.5 degrees Fahrenheit. Review of Resident 31's Medication Administration Records (MAR) and Treatment Administration Records (TARs), as well as the resident's clinical record revealed that there was no documented evidence that the resident's temperature was obtained as ordered during the daylight and/or evening shifts on January 9 and 10, 2022, and during the evening shifts on January 8, and 11, 2022. Interview with Registered Nurse 4 on January 12, 2022, at 12:00 p.m. confirmed that there was no documented evidence that Resident 31's temperatures were taken as ordered on the above listed dates. 28 Pa. Code 211.12(d)(1)(5) Nursing services.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. 38012 Based on clinical record reviews and staff interviews, it was determined that the facility failed to initiate nutritional interventions to prevent weight loss for one of 46 residents reviewed (Resident 67). Findings include: An annual Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 67, dated December 18, 2021, revealed that the resident was confused (unable to make sound decisions) and required maximum assistance from staff for his meals. Weight records for Resident 67 revealed that the resident experienced a 15.6 percent (severe) unplanned weight loss in one month from October 12, 2021, to November 1, 2021, when he dropped to 168.8 pounds. There was no documented evidence that Resident 67's weight loss was assessed or that any new interventions to prevent further weight loss were initiated. A dietary note for Resident 67, dated December 17, 2021, indicated that the the resident had an unplanned weight loss, had a feeding tube (a tube inserted surgically into the intestines to provide nutrition), and would be weighed weekly. According to the resident's medical record his weight was not obtained weekly as ordered. Interview with the Dietitian on January 12, 2022, at 11:10 a.m. confirmed that Resident 67 had a significant weight loss, that no interventions to prevent further weight loss were initiated, and the physician was not notified about the resident's weight loss or gain. Interview with the Director of Nursing on January 12, 2022, at 12:15 p.m. revealed that the dietician is expected to intervene when residents have unplanned weight loss or gain and that the resident should have been weighed weekly as ordered by the dietician. 28 Pa. Code 211.12(d)(3) Nursing services. 28 Pa. Code 211.12(d)(5) Nursing services.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide for the safe, appropriate administration of IV fluids for a resident when needed. 20550 Based on review of policies and clinical records, as well as observations and staff interviews, it was determined that the facility failed to ensure proper infusion of Total Parenteral Nutrition (TPN) and flushing of the port for one of 46 residents reviewed (Resident 16) that were receiving TPN, and failed to ensure that long-term intravenous catheters were flushed according to the facility's policy (professional standards) for two of 46 residents reviewed (Residents 63, 86). Findings include: The manufacturer's instructions for the TPN infusion pump, undated, indicated to confirm safe operation at start and that only trained health care professionals could operate the infusion equipment. The staff were to confirm that the pump settings were as intended by confirming the correct patient, route, dose rate, dose mode, time and concentration. The pump Operating System is not intended to replace clinician patient observation. When using the pump, periodic patient monitoring must be performed to ensure that the infusion is proceeding as intended. The facility policy for parental nutrition, dated December 29, 2021, indicated that TPN must be given through a central venous access device and regulated via an electronic pump. The parental nutrition should have a physician's order for the treatment, and the order should include the formula or list of all individual ingredients/nutrients in the same base solution, total volume, and the rate of administration. The orders for the TPN and the TPN bag labels must match; otherwise contact the pharmacy. The procedure for infusion indicated that first the staff were to verify the order and compare orders with the label on the bag. Set the pump with the prescribed rate and volume. Monitor the resident, the insertion site and flow at regular intervals (at least every two hours). The record documentation should include the person monitoring the infusion, the rate, and volume infused with additives added. The diagnosis record for Resident 16, dated June 6, 2021, included post surgical malabsorption (nutrients not absorbed properly in the stomach), diabetes (a disease which causes blood sugar fluctuations), protein calorie malnutrition, fistula (abnormal connection between organs) of the stomach and the duodenum, and colostomy (operation in which a piece of the colon is diverted to an artificial opening in the abdominal wall). The physician's orders for Resident 16, dated November 1, 2021, indicated that staff were to provide 2200 mililiters (ml) intravenously (directly into the vein) in the evening every Tuesday, Thursday, and Sunday, at the rate of 80 ml for one hour, then 157 ml for 13 hours, then 80 ml for one hour then discontinue. The solution should include: Infuvite (multivitamin) total of 10 ml added and provide 2600 ml intravenously in the evening every Monday, Wednesday, Friday, and Saturday, at the rate of 78 ml for one hour, then increase to 188 ml for 13 hours, then decrease to 78 ml for one hour. The solution was to include Infuvite 10 ml and SMOFlipids (an alternative lipid- fatty acids-emulsion). (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The order form for the parental nutrition for Resident 16, signed by the pharmacist and documented per the physician, dated November 1, 2021, indicated that the TPN solution for Monday, Wednesday, Friday and Saturday should have a total volume of 2400 ml, which included 50 ml of SMOFlipids and should by cycled over 15 hrs. The total amount of infusion per this written order did not match the entered physician order above. The medication administration record for Resident 16, dated January 8, 2022, indicated that Registered Nurse 5 added 10 ml of infuvite IV and attached the TPN at 7:01 p.m. with a volume of 2600 ml, which included SMOFlipids (as per the entered physician's order on the computer record and not the original hard copy order). Observations of Resident 16 on January 9, 2022, at 10:10 a.m. indicated that a bag of TPN solution with approximately 250 ml of solution remained in the bag, which was disconnected from the resident and was out of the infusion pump. The pharmacy label on the bag indicted that it contained total TPN volume of 2400 cc with no overfill and that it was to infuse over 15 hours on Monday, Wednesday, Friday and Saturday. The registered nurse was to add 10 ml of multivitamin and the infusion rate was to be 85.71 for one hour, 171.43 for 13 hours, and at 85.71 for one hour using tubing with a filter, and that the total volume was to be 2400 cc. Observation with Licensed Practical Nurse 6 on January 9, 2022, at 2:09 p.m. confirmed that the pump screen indicated that the settings were a main rate of 178 ml per hr, and the amount to be infused 2400 ml and 15 hr total time of infusion - ramp up rate for 1 1/2 hrs, main step for 12 hrs, tapered down for 1 1/2 hrs. She was unaware why there was still solution in the TPN bag. Interview with Registered Nurse 5 on January 9, 2022, at 3:06 p.m. indicated that the infusion pump comes from the pharmacy and confirmed that the tag on the pump infusion device was dated November 1, 2021. He further indicated that the nurses change the total volume to be infused and demonstrated he was able to change the rate; however, he indicated that he was unable to set the rate and time for the ramp up and down time and that the pumps were set by the pharmacy and he did not change it. He was unaware of how to visualize what the settings were on the pump for the ramp up and down times. He was unaware why there was remaining solution in the bag of TPN after the completion of the infusion. Interviews with Pharmacists 7 and 8, and the QA Director respectively on January 10, 2022, at 12:36 p.m., 2:45 p.m. and 4:00 p.m. indicated that the TPN solution had not been changed since the original order on November 1, 2021. The total volume sent from the pharmacy should be infused and they confirmed that there was no additional amount (overfill) of solution in the bag. The rates were to be changed by the nurse and that the pharmacy does not do any setting of the infusion pump since the daily solution does change. The TPN with lipids total of 2400 ml should have been infused and there should not have been any solution left. The facility's policy for parenteral nutrition, dated December 29, 2021, indicated that the steps in the procedure for initiation of TPN included cleaning the end of the needleless device on the catheter with alcohol, then flush the catheter with 0.9 percent normal saline, then attach the TPN bag. The physician's order for Resident 16, dated November 1, 2021, included an order for Normal Saline Flush Solution 0.9 percent (Sodium Chloride Flush), use 10 cc intravenously as needed for TPN ordered before each medication administration. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There was no documented evidence that the port for infusion was flushed prior to infusion set up or when the infusion was completed daily. Interview with the Director of Nursing on January 12, 2022, at 11:47 a.m. indicated that staff are to flush before and after the TPN is completed and that there was no documented evidence this was completed with each infusion of TPN. She also confirmed that there was no evidence of every two hours checking of the resident, the site and infusion as per the facility policy and that staff did not have any evidence of specific education regarding the TPN infusion pump usage at this facility. The facility's policy regarding midline catheter flushing, dated December 29, 2021, revealed that staff are to flush catheters at regular intervals to maintain patency and before and after the following: administration of intermittent solutions, administration of medications, administration of blood or blood products, obtaining blood samples, and/or converting from continuous to intermittent therapies. Flushing when giving medications SAS method (saline, administer, saline). Connect 10 milliliters (ml) syringe containing saline (amount as ordered or per facility protocol) to catheter via injection or access device. Flush with saline (amount established by pharmacy or facility protocol) using push-pause method. Connect the medication. Administer the medication. Disconnect the medication from the access device. Connect another 10 ml syringe containing saline (amount as ordered or per facility protocol) to catheter via injection or access device. Flush with saline (amount established by pharmacy or facility protocol). Flush at the same rate of injection as the medication. Disconnect the syringe. Physician's orders for Resident 63, dated January 2, 2022, included an order for the resident to receive a midline or peripheral line to receive fluids intravenously (IV - administered into a vein) one time only. Physician's orders for Resident 63, dated January 2, 2022, included an order for the resident to receive two liters on Sodium Chloride Solution 0.9 percent (solution used to replace lost body fluids and salts) intravenously for one day continuous at a rate of 100 milliters per hour for dehydration. Physician's orders for Resident 63, dated January 4, 2022, included an order for the resident to receive two liters on Sodium Chloride Solution 0.9 percent (fluid used to replace lost body fluids and salts) intravenously every ten hours at a rate of 100 milliters per hour for dehydration. A nursing note on January 10, 2022, for Resident 63 revealed that there was a new order received to discontinue the IV midline and it was removed. Resident 63's Medication Administration Records (MAR's) for January 2022, revealed that staff administered the Sodium Chloride 0.9 percent as ordered by the physician on January 2, 4, and 5, 2022, at the scheduled time. However, there was no documented evidence that Resident 63's midline was flushed with a saline solution every shift at regular intervals to maintain patency while the Resident 63 was ordered the midline. Interview with the Director of Nursing on January 11, 2022, at 4:09 p.m. and January 12, 2022, at 11:32 a.m. confirmed that there was no documented evidence that Resident 63's midline was flushed with a saline solution every shift to maintain patency, and the resident did not have the midline discontinued until after it was decided if other treatments were necessary. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Physician's orders for Resident 86, dated January 3, 2022, included an order for the resident to receive 250 milligrams (mg) of Levofloxacin (an antibiotic) intravenously (IV - administered into a vein) one time a day for three administrations. Resident 86's Medication Administration Records (MAR's) for January 2022 revealed that staff administered the IV Levofloxacin as ordered by the physician on January 4, 5, and 6, 2022, at 9:00 a.m. However, there was no documented evidence that Resident 86's midline was flushed with a saline solution before and after the administration of the Levofloxacin. Interview with Registered Nurse Supervisor 4, January 12, 2022, at 12:00 p.m. confirmed that there was no documented evidence that Resident 86's midline was flushed with a saline solution before and after the administration of Levofloxacin.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 20550 Based on the review of the clinical records, review of facility policies as well as observations and staff interviews, it was determined that the facility failed to ensure the provision of oxygen therapy depending on the resident's needs and physician orders for one of the 46 residents (Resident 56). Findings include: The facility policy for oxygen therapy, dated December 29, 2021, indicated that staff were to verify the physician order for oxygen therapy. After completing the oxygen set up or adjustment, information should be recorded in the resident's medical record: the name and title of the individual who performed the procedure, the oxygen flow rate, route, and rationale, and all assessment data obtained before, during and after the procedure. The diagnosis record for Resident 56 dated March 2, 2020 included exacerbation of COPD (chronic obstructive pulmonary disease (disease which blocks the airflow and makes it difficult to breathe), respiratory failure (your blood does not have enough oxygen) and Guillain barre syndrome (immune system attacks the nerves). The physician's order for Resident 56, dated October 5, 2021, included an order for the tracheostomy (open airway directly into the trachea) to be in use. The physician's order for Resident 56, dated October 6, 2021, included an order that the resident was to be provided oxygen via ATM (aerosol trachea mask - mask which goes over a tracheostomy) at .21-1.0 or 0-15 LPM (liter per minute-flow rate) to maintain oxygen saturations (percentage of oxygen in the blood) greater than or equal to 90 percent. The respiratory documentation for Resident 56, on January 1-9, 2022, for the day shift indicated that he was on oxygen at 2 liters (flow rate) daily via trachea mask. The documentation by Respiratory Therapist 9 further indicated that at on January 9, 2022, at 8:28 a.m. he was provided a respiratory treatment, was suctioned, and that he was on oxygen at the 2 liter flow rate. Observations on January 9, 2022, at 10:21 a.m., 11:05 a.m., and 11:06 a.m. revealed that Resident 56 had a trachea mask in place and that the wall oxygen gauge was not registering and that it was not set at any flow rate (not on). Interview with Licensed Practical Nurse 10 on January 9, 2022, at 11:06 a.m. confirmed that the oxygen was not on and that Resident 56 should have been receiving oxygen at 2 liters. Interview with Respiratory Therapist 11 and Respiratory Therapist 9 on January 9, 2022, respectively at 11:17 a.m. and at 2:19 p.m., indicated that Resident 56 was to be on oxygen flow rate of 2 liters during the day and that they were not attempting to titrate (decrease his flow rate) to room air and they did not know why the flow rate was not at 2 liters. (continued on next page)

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	395500	A. Building B. Wing	01/12/2022

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

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Director of Nursing on January 10, 2022 at 2:16 p.m. indicated that the oxygen was ordered to be titrated (flow rate decreased as tolerated) and that the oxygen should have been set at the correct liter flow rate as indicated by the staff caring for the resident during that shift. 28 Pa. Code 211.12(d)(5) Nursing services.

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. 31760 Based on review of clinical records, as well as staff interviews, it was determined the facility failed to demonstrate adequate physician supervision of resident care including the attending physician awareness of a resident's significant weight loss for two of 46 residents reviewed with a significant weight loss (Residents 58, 67). Findings include: Review of Resident 58's clinical record revealed that the resident had a diagnosis which included cancer, Parkinson's disease (a brain disorder that leads to shaking, stiffness, and difficulty with walking, balance, and coordination), and hypothyroidism (a condition in which your thyroid gland does not produce enough of certain crucial hormones). A care plan for Resident 58, dated September 14, 2021, revealed that the resident had a concern for nutritional risk and that staff was to notify the physician and responsible party of significant weight changes. A nutrition note for Resident 58, dated October 10, 2021, revealed that the resident had a weight warning from a weight which was obtained on October 8, 2021, of 232.8 pounds, which represented a 8.3 percent weight change for the resident in 90 days. His weight history revealed that on June 23, 2021, the resident's weight was 256.4 pounds; on July 15, 2021, his weight was 253.8 ponds; on August 10, 2021, his weight was 239.2 pounds; and on September 14, 2021, his weight was 235.6 pounds. Weight appears to be trending down. Intakes may be slightly lower than from the previous nutrition review. Will add between-meal snacks to help boost energy intakes, promote weight maintenance. Will continue to monitor weight, intakes and adjust nutrition plan of care as needed. A nutrition note for Resident 58, dated November 4, 2021, revealed that a weight loss was noted. Percent of weight change noted at 8.3 percent in three months. Tolerating diet and has good oral intake. Significant weight loss in 90 days noted. Continue current diet. Encourage good oral intake of meals and fluids. Monitor labs, oral intake, and weight. Care plan reviewed and revised as appropriate based on evaluation. A nutrition note for Resident 58, dated December 9, 2021, revealed that a weight loss was noted. Percent of weight change noted at 17 percent in six months. Noted a significant weight loss. Weight down most likely related to a hospital stay, illness, and start of dialysis (a procedure to remove waste products and excess fluid from the blood when the kidneys stop working properly). Resident may benefit from protein supplement as protein needs increase with dialysis. Continue diet as ordered. Encourage good oral intake of meals. Monitor labs, oral intake and weight. Care plan reviewed and revised as appropriate based on evaluation. A quarterly Minimum Data Set assessment (MDS - a federally mandated standardized assessment process conducted at defined intervals to plan resident care) for Resident 58, dated December 10, 2021, revealed that the resident's weight was 219 pounds, which indicated that it was a loss of 5 percent or more in the last month or loss of 10 percent or more in last 6 months and that the resident was not on prescribed weight-loss regimen. (continued on next page)

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	However, there was no documented evidence that Resident 58's physican addressed and/or was made aware of the resident's significant weight loss. An annual Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 67, dated December 18, 2021, revealed that the resident was confused (unable to make sound decisions), and required maximum assistance from staff for his meals. Weight records for Resident 67 revealed that the resident experienced a 15.6 percent (severe) unplanned weight loss in one month when his weight dropped to 168.8 pounds from October 12, 2021, to November 1, 2021. There was no documented evidence that Resident 67's weight loss was assessed or that any new interventions to prevent further weight loss were initiated or that the physician was notified regarding the weight loss. A dietary note for Resident 67, dated December 17, 2021, indicated that the the resident had an unplanned weight loss, had a feeding tube (a tube inserted surgically into the intestines to provide nutrition), and would be weighed weekly. According to the resident's medical record his weight was not obtained weekly as ordered. Interview with Registered Dietitian 12 on January 12, 2022, at 11:10 a.m. confirmed that Resident 67 had a significant weight loss, that no interventions to prevent further weight loss were initiated, and the physician was not notified about the resident's weight loss or gain. She further stated that she did not notify the physician about Resident 67's weight loss because she believed it was nursing's responsibility to do so. Interview with the Director of Nursing on January 12, 2022, at 12:15 p.m. revealed that the dietician is expected to intervene when residents have unplanned weight loss or gain and that the resident should have been weighed weekly as ordered by the dietician. Interview with Registered Nurse 4, on January 12, 2022, at 12:00 p.m., revealed that if a resident is identified by nursing with a weight loss, they would put a referral into the dietitian and notify the physician. Interview with Registered Dietitian 12 on January 12, 2022, at 12:15 p.m. and 12:20 p.m. revealed that she does not notify the physician of weight loss in a resident, that it is the role of nursing. 28 Pa. Code 211.2(a)(b)(d)(2) Physician services. 28 Pa. Code 211.6(d) Dietary Services 28 Pa. Code 211.12 (c)(d)(3)(5) Nursing services

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 31760 Based on review of facility policy, a list of nurse aides provided by the facility, and the nurse aides' personnel files, as well as staff interviews, it was determined that the facility failed to ensure that nurse aide performance evaluations were completed annually based on hire dates for four of four nurse aides reviewed (Nurse Aides 13, 14, 15, 16). Findings include: The facility's policy regarding performance evaluations, dated December 29, 2021, revealed that a performance evaluation will be completed on each employee at the conclusion of his/her 90-day probationary period, and at least annually thereafter. The completed performance evaluation will be sent by the director or supervisor to the human resources director to be placed in the employee's personnel record. A copy will be provided to the employee. A list of nurse aides provided by the facility revealed that based on their months and days of hire, annual performance evaluations were due between January 3, 2020, and October 29, 2021. However, there was no documented evidence that annual performance evaluations were completed as required for Nurse Aides 13, 15, and 16. A list of nurse aides provided by the facility revealed that Nurse Aide 14 had a hire date of April 8, 2002. Nurse Aide 14's personnel file revealed that the she had a performance evaluation completed on February 4, 2020. However, there was no documented evidence that her annual performance evaluation was completed as required in 2021. Interview with the Nursing Home Administrator on January 12, 2022, at 1:50 p.m. confirmed that she could provide no evidence that annual performance evaluations were completed as required for the above nurse aides. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(b)(1)(3) Management. 28 Pa. Code 201.18(e)(1) Management. 28 Pa. Code 201.20(a) Staff development. 28 Pa. Code 201.20(c) Staff development.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31760 Based on review of facility policies, resident interviews, observations, and staff interviews, it was determined that the facility failed to serve food items at appetizing temperatures. Findings include: The facility's policy regarding food preparation, dated December 29, 2021, revealed that all foods will be held at appropriate temperatures, greater than 135 degrees Fahrenheit (F) (or as state regulation requires) for hot holding and less than 41 degrees F for cold food holding. The facility's policy regarding food quality and palatability, dated December 29, 2021, revealed that food will be prepared by methods that conserve nutritive value, flavor and appearance. Food will be palatable, attractive, and served at a safe and appetizing temperature. Interviews with Residents 9, 30, 33, 36, 59, 61, and 78 on January 9, 2022, during the initial survey sampling process revealed that the food served by the facility at meal times did not taste good, was not served hot enough, and that their meals arrive with food being cold. Interview with Resident 53 during the resident group meeting on January 10, 2022, at 2:00 p.m. revealed that she was disappointed with the quality of the food served at the facility and voiced a concern that her breakfast is usually cold and she is one of the first residents to be served. Observations in the main kitchen on January 10, 2022, revealed that the [NAME] Unit second meal cart left the main kitchen at 12:28 p.m. and arrived on the [NAME] Unit at 12:29 p.m. Trays were passed to the residents in their rooms at 12:30 p.m. and the last resident was served at 12:38 p.m. At 12:39 p.m. the temperature of the Pork Roast was 116.6 degrees F, the temperature of the Brussel Sprouts was 127 degrees F, the temperature of the stuffing was 143.2 degrees F, the temperature of the coffee was 155.4 degrees F, the temperature of the white milk was 48 degrees F, the temperature of the juice was 53 degrees F, and the temperature of the ice cream was 10.6 degrees F. The Pork Roast was lukewarm to taste and not appetizing. Interview with the Dietary Account Manager at the time of the observation revealed that she likes her food to be hotter. Interview with the District Dietary Manager on January 10, 2022, at 2:15 p.m. revealed that when they perform their test trays, they expect their hot foods, when delivered to the resident, should be equal to or greater than 110 degrees F.