STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395500	A. BUILDING _____ B. WING _____	**08/27/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
TWIN LAKES REHABILITATION AND HEALTHCARE CENTER	**227 SAND HILL ROAD GREENSBURG, PA 15601**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0554 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Allow residents to self-administer drugs if determined clinically appropriate.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of policies and clinical records, as well as observations and staff interviews, it was determined that the facility failed to determine if residents were safe to self-administer medications for one of 41 residents reviewed (Resident 53). Findings include: The facility's policy regarding the self-administration of medications by residents, dated December 31, 2019, indicated that for residents who desired to self-administer medications, a staff and practitioner assessment of the resident's mental and physical abilities would be completed as part of an overall evaluation to determine whether self-administering medications is clinically appropriate for the resident. In addition to a general evaluation of decision-making capacity, the staff and practitioner would perform a more specific skill assessment, including (but not limited to) the resident's ability to read and understand medication labels; comprehension of the purpose and proper dosage and administration time for his or her medications; the ability to remove medications from a container and to ingest and swallow (or otherwise administer) the medication; and the ability to recognize risks and major adverse consequences of his or her medications. An admission Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 53, dated June 26, 2019, indicated that the resident was cognitively intact, was understood and could understand others. A [DIAGNOSES REDACTED]. Physician's orders dated June 19, 2020, included an order for [REDACTED]. Interview with the Director of Nursing and Nursing Home Administrator on August 26, 2020, at 4:13 p.m. confirmed that Resident 53 was not evaluated and did not have a physician's order to self-administer medications and should not have had medications at her bedside. 28 Pa. Code 211.10(c) Resident care policies 28 Pa. Code 211.12(d)(1)(5) Nursing services.
F 0658 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure services provided by the nursing facility meet professional standards of quality.** Based on review of the Pennsylvania Nursing Practice Act, facility policy, and residents' clinical records, as well as staff interviews, it was determined that the facility failed to ensure that a professional (registered) nurse assessed a change in the condition in a timely manner for one of 41 residents reviewed (Resident 54). Findings include: The Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.11 (a)(1)(2)(4) indicated that the registered nurse was to collect complete and ongoing data to determine nursing care needs, and was responsible for assessing human responses and plans, implementing nursing care, and analyzing/comparing data with the norm in determining care needs. The facility's policy regarding changes in condition, dated December 31, 2019, indicated that nurse aides would be trained in recognizing subtle but significant changes in a resident's condition and how to communicate the changes to the nurse. Nursing staff was to then make detailed observations and collect pertinent information to be presented to the physician. Review of the facility's investigation of an area of redness and pain on Resident 54's left knee, dated August 23, 2020, revealed that witness statements were collected from staff regarding the discovery of the area. These witness statements included statements from nurse aides indicating that they reported the new area of redness to the registered nurse supervisor during the night shift on August 21, 2020. A witness statement completed by Nurse Aide 4, dated August 23, 2020, revealed that while performing care for Resident 54 at 1:00 a.m. on August 21, 2020, she noticed a red mark on the resident's knee, and at 3:00 a.m, she noticed the red mark was bigger, the resident's knee was out to the side, and the resident would not straighten her knee out. The statement indicated that she called Registered Nurse Supervisor 5 in to check the resident's knee. Nurse Aide 4's statement also indicated that the next evening on August 22, 2020, Resident 54's knee was still reddened and bent, and she asked Nurse Supervisor 6 to check it and also passed this information on to the oncoming nurse aide staff before leaving both mornings. A witness statement completed by Nurse Aide 7, dated August 24, 2020, revealed that on the night shift (Thursday, August 20, into Friday, August 21, 2020) Nurse Aide 4 discovered that Resident 54's leg was bent, she was complaining of pain, and she would not stretch her leg out or move it up and down. Nurse Aide 7's statement indicated that Nurse Aide 4 reported this to Registered Nurse Supervisor 5. However, there was no documented evidence that Resident 54's knee was assessed by a professional (registered) nurse until August 23, 2020, (two days after the issue was reported by the nurse aide). Interview with the Director of Nursing on August 26, 2020, at 3:10 p.m. confirmed that there was no documented evidence that Resident 54's knee was assessed by a registered nurse until August 23, 2020, and it should have been assessed on August 21, 2020. 28 Pa. Code 211.12(d)(1)(5) Nursing services.
F 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that physician's orders [REDACTED].) of administration before giving the medication. physician's orders [REDACTED]. The controlled substance record for Resident 77's [MEDICATION NAME], dated July 27, 2020, revealed that staff signed out only one capsule for administration, instead of two capsules, at 2:00 p.m. and 9:00 p.m. The controlled substance record for Resident 77's [MEDICATION NAME], dated August 6, 2020, revealed that staff signed out two capsules to administer to the resident at 5:18 a.m. and signed out one capsule again at 6:14 a.m. The controlled substance record for Resident 77's [MEDICATION NAME], dated August 7, 2020, at 2:00 p.m. revealed that staff signed out only one capsule for administration, instead of two capsules. The controlled substance record for Resident 77's [MEDICATION NAME], dated August 8, 2020, at 6:00 a.m. revealed that staff signed out only one capsule for administration, instead of two capsules. Interview with the Director of Nursing on August 27, 2020, at 2:15 p.m. confirmed that Resident 77 did not receive the correct dose of [MEDICATION NAME] on the above dates as ordered by the physician. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 43, dated June 23, 2020, revealed that the resident was in a persistent vegetative state (a condition of profound nonresponsiveness in the wakeful state caused by brain damage), had contractures (shortening of the muscles and/or tendons that often leads to rigidity and/or deformity of the joints) of both hands and legs, and was dependent on staff for all of her care. The resident's care plans, dated June 9, 2020, included that staff were to turn and reposition the resident every two hours or as tolerated, to apply a green bean bag bolster between the resident's knees while in bed, to apply bilateral hand palm guards (due to contractures) at bedtime and remove them in the morning with care, and to apply a right elbow splint (used to treat contractures) at bedtime and remove it the morning with care. Current physician's orders [REDACTED]. reduction and wound healing. Observations of Resident 43 on August 26, 2020, at 10:48 a.m. revealed that she was lying in bed on her back with a green bean bag bolster between her legs, and bilateral palm guards and a right elbow splint in place. Observations of Resident 43 on August 26, 2020, at 2:12 p.m. revealed that she was still lying in bed on her back with a green bean bag bolster between her legs, and bilateral palm guards and a right elbow splint in place. The resident was moaning and pulling at her hair. Interview with Nurse Aide 3 on August 26, 2020, at 2:12 p.m. confirmed that Resident 43's bilateral palm

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

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395500	A. BUILDING _____ B. WING _____	08/27/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
TWIN LAKES REHABILITATION AND HEALTHCARE CENTER	227 SAND HILL ROAD GREENSBURG, PA 15601

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) guards and right elbow splint were to be removed with morning care. Interview with the Director of Nursing on August 27, 2020, at 12:36 p.m. confirmed that Resident 43's bilateral palm guards and right elbow splint should have been removed with morning care as ordered by the physician. 28 Pa. Code 211.12(d)(5) Nursing services.
F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, observations and staff interviews, it was determined that the facility failed to ensure that appropriate treatment and services were provided to promote healing of pressure ulcers for one of 41 residents reviewed (Resident 43) who had a pressure ulcer. Findings include: A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 43, dated June 23, 2020, revealed that the resident was in a persistent vegetative state (a condition of profound nonresponsiveness in the wakeful state caused by brain damage), had a Stage four pressure ulcer (the most severe type of pressure ulcer in which the muscle and/or bone are exposed) of the left sacrum (area at the base of the spine), contractures (shortening of the muscles and/or tendons that often causes rigidity and/or deformity of the joints) of both hands and legs, had an indwelling urinary catheter (a tube inserted and held in the bladder to drain urine), was incontinent of bowel, and was dependent on staff for all of her care. Resident 43's care plan regarding the Stage four pressure ulcer, dated June 2, 2020, revealed that sitting time out of bed was to be limited to two hours per day; pillows were to be placed between bony prominences; the resident's heels were to be kept elevated as needed; staff were to minimize skin exposure from incontinence, perspiration or wound drainage; keep the skin clean and dry; avoid positioning the resident directly on the trochanter (the two bony hip protuberances); and use a bed wedge for side lying positioning. Current physician's orders [REDACTED]. Observations of Resident 43 on August 26, 2020, at 10:48 a.m. revealed that she was in bed on her back and the head of her bed was elevated 30 degrees. The bed wedge was not in place and the resident's sacral area was in contact with the mattress. There was a green bean bag bolster between her legs, which were bent at the knees, and the resident was moaning. Observations of Resident 43 on August 26, 2020, at 2:12 p.m. revealed that she was in bed on her back and the head of her bed was elevated 30 degrees. The bed wedge was not in place and the resident's sacral area was in contact with the mattress. There was a green bean bag bolster between her legs and the resident was moaning and pulling at her hair. Interview with Nurse Aide 3 on August 26, 2020, at 2:12 p.m. confirmed that Resident 43 had not been checked or repositioned since before 11:00 a.m. Nurse Aide 3 stated that the resident moans constantly and that when she is in pain her face gets red, she clenches her fists, and pulls her hair. Interview with the Director of Nursing on August 27, 2020, at 12:36 p.m. confirmed that Resident 43 should have been repositioned between 11:00 a.m. and 2:12 p.m. 28 Pa. Code 211.12(d)(1)(5) Nursing services.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that each resident received adequate supervision and assistance devices to prevent accidents, by failing to thoroughly investigate accidents/incidents for one of 41 residents reviewed (Resident 41). Findings include: The facility's policy regarding investigating accidents and incidents, dated December 31, 2019, indicated that all accidents/incidents involving residents were to be investigated and include the names of witnesses and their accounts of the accident/incident. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 41, dated June 18, 2020, revealed that the resident was severely cognitively impaired, required extensive assistance or was totally dependent on staff for daily care tasks and mobility, was unable to eat and received nutrition via a gastrostomy tube (a tube inserted through the abdominal wall into the stomach as a means to deliver nutrition), and had a [MEDICAL CONDITION] (surgically created hole through the neck into the windpipe that enables air to enter or be delivered to the lungs), and was ventilator dependent (required a mechanical breathing machine that moves air into and out of the lungs). The resident's care plan, dated March 13, 2020, revealed that she was at risk for falls, used a specialty mattress with bolsters (long thick pillows used for support or to provide a perimeter) and bilateral fall mats (padded mats placed on the floor to provide a softer landing in the event of a fall from bed). An Incident/Accident Investigation worksheet for Resident 41 revealed that on July 4, 2020, at 4:20 p.m., nurse aides found the resident face down on the floor on the left side of her bed. The report indicated that Resident 41 was placed back into her bed and the bolsters were repositioned and tightened. There was no documented evidence that witness statements were obtained from the nurse aides who found Resident 41 on the floor, or from any other staff that may have seen or cared for Resident 41 prior to her fall. There was also no documented evidence regarding whether or not the bolsters were in place and properly positioned when last observed by staff. Interview with the Director of Nursing on August 26, 2020, at 3:05 p.m. confirmed that there was no documented evidence that witness statements were completed after Resident 41's fall on July 4, 2020, and witness statements should have been completed. 28 Pa. Code 201.18(e)(1) Management. 28 Pa. Code 211.12(d)(5) Nursing services.
F 0725 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the Facility Assessment and residents' clinical records, as well as observations and staff interviews, it was determined that the facility failed to ensure that sufficient staffing was available to provide nursing care in accordance with resident care plans for one of 41 residents reviewed (Resident 43). Findings include: The Facility Assessment, dated August 6, 2020, revealed that in order to provide competent support and care for the resident population every day and during emergencies, the following staffing assignments (determined based on the clinical needs of residents, and balanced as able to ensure adequate care and services are provided to meet highest practicable levels of physical, mental and psychosocial well-being) were to be maintained. The predicted staffing that was required for the day shift on the(NAME)unit was two licensed nurses and four nurse aides. A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 43, dated June 23, 2020, revealed that the resident was in a persistent vegetative state (a condition of profound nonresponsiveness in the wakeful state caused by brain damage), had a Stage four pressure ulcer (the most severe type of pressure ulcer in which the muscle and/or bone are exposed) of the left sacrum (area at the base of the spine), contractures (shortening of the muscles and/or tendons that often causes rigidity and/or deformity of the joints) of both hands and legs, had an indwelling urinary catheter (a tube inserted and held in the bladder to drain urine), was incontinent of bowel, and was dependent on staff for all of her care. Resident 43's care plans, dated June 9, 2020, included that staff were to turn and reposition the resident every two hours or as tolerated, to apply a green bean bag bolster between the resident's knees while in bed, to apply bilateral hand palm guards (due to contractures) at bedtime and remove them in the morning with care, and to apply a right elbow splint (used to treat contractures) at bedtime and remove it in the morning with care. Resident 43's care plan regarding the Stage four pressure ulcer, dated June 2, 2020, revealed that sitting time out of bed was to be limited to two hours per day; pillows were to be placed between bony prominences; the resident's heels were to be kept elevated as needed; staff were to minimize skin exposure from incontinence, perspiration or wound drainage; keep the skin clean and dry; avoid positioning the resident directly on the trochanter (the two bony hip protuberances); and use a bed wedge for side lying positioning. Current physician's orders [REDACTED]. reduction and wound healing. Observations of Resident 43 on August 26, 2020, at 10:48 a.m. revealed that she was in bed on her back and the head of her bed was elevated 30 degrees. The bed wedge was not in place and the resident's sacral area was in contact with the mattress. There was a green bean bag bolster between her legs, which were bent at the knees, and the resident was moaning. Observations of Resident 43 on August 26, 2020, at 2:12 p.m. revealed that she was in bed on her back and the head of her bed was elevated 30 degrees. The bed wedge was not in place and the resident's sacral area was in contact with the mattress. There was a green bean bag bolster between her legs and the resident was moaning and pulling at her hair. Interview with Nurse Aide 3 on August 26, 2020, at 2:12 p.m. confirmed that Resident 43's bilateral palm guards and right elbow splint were to be removed with morning care and that the resident was not checked or repositioned since before 11:00 a.m. because staffing went down to two nurse aides on the unit (Palmer) at 11:00 a.m. and they were trying to take care of 46 residents. Nurse Aide 3 stated that the resident moans constantly and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395500	A. BUILDING _____ B. WING _____	08/27/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
TWIN LAKES REHABILITATION AND HEALTHCARE CENTER	227 SAND HILL ROAD GREENSBURG, PA 15601

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0725 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) that when she is in pain her face gets red, she clenches her fists, and pulls her hair. Interview with the Director of Nursing on August 27, 2020, at 12:36 p.m. revealed that Resident 43's hospice aide was on the unit until 11:00 a.m. on August 26, 2020, and there were only two nurse aides on the unit for the remainder of the shift. The Director of Nursing also confirmed that Resident 43 should have been repositioned between 11:00 a.m. and 2:12 p.m., and her bilateral palm guards and right elbow splint should have been removed with morning care as ordered. 28 Pa. Code 201.18(e)(1) Management. 28 Pa. Code 211.12(d)(5) Nursing services.
F 0729 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Verify that a nurse aide has been trained; and if they haven't worked as a nurse aide for 2 years, receive retraining.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policies and personnel files, as well as staff interviews, it was determined that the facility failed to receive registry verification prior to allowing individuals to work as a nurse aide for two of two newly hired nurse aides reviewed (Nurse Aides 1 and 2). Findings include: The facility's policy regarding abuse prevention, dated December 31, 2019, revealed that as part of resident abuse prevention, the administrator would conduct employee background checks and would not knowingly employ or otherwise engage any individual who had a finding of abuse, neglect, exploitation, mistreatment of [REDACTED]. The personnel file for Nurse Aide 1 revealed that she was hired by the facility on July 2, 2020, and time punches revealed that she worked in the facility between July 7 and August 12, 2020. However, there was no documented evidence that the facility verified the nurse aide's standing with the state nurse aide registry until August 24, 2020. The personnel file for Nurse Aide 2 revealed that she was hired by the facility on July 9, 2020, and time punches revealed that she worked in the facility between July 10 and August 25, 2020. However, there was no documented evidence that the facility verified the nurse aide's standing with the state nurse aide registry until August 24, 2020. Interview with the Director of Nursing on August 26, 2020, at 4:45 p.m. confirmed that registry checks for Nurse Aides 1 and 2 were not completed until August 24, 2020, and that they should have been completed prior to the aides working in the facility. Interview with the Nursing Home Administrator on August 26, 2020, at 5:05 p.m. revealed that while performing audits, it was discovered that the two nurse aide registry checks were missed, so the Human Resources Director developed a checklist on August 21, 2020, that included items to be completed prior to and following employment, including nurse aide registry checks. The facility's corrective actions taken included: On August 21, 2020, all personnel files for recently hired nurse aides were reviewed. On August 21, 2020, a new employee checklist was created, which included all required information for new employees' personnel files, including nurse aide registry checks. On August 24, 2020, all missing nurse aide registry checks were completed. As of August 24, 2020, an audit showed that registry checks were completed for all recently hired nurse aides. 28 Pa. Code 201.29 Personnel policies and procedures.
F 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to maintain a complete and accurate accounting of controlled medications (medications with the potential to be abused) for three of 41 residents reviewed (Residents 11, 14, 77). Findings include: The facility's policy regarding medication administration, dated December 31, 2019, indicated that the individual who administered the medication must initial the resident's Medication Administration Record [REDACTED]. As required or indicated for a medication, the individual who administered the medication was to record the date and time the medication was administered in the resident's medical record, and was to document their signature and title. physician's orders [REDACTED]. on August 9, 11, 12, 15 and 24, 2020. However, the resident's clinical record, including the MAR, contained no documented evidence that the [MEDICATION NAME] was actually administered to the resident on those dates. Interview with the Director of Nursing on August 27, 2020, at 2:15 p.m. confirmed that there was no documented evidence that the doses of [MEDICATION NAME] that were signed-out were actually administered to Resident 11 on the above dates. physician's orders [REDACTED]. and 24, and August 7, 8, 15, 16 and 23, 2020. However, the resident's clinical record, including the MAR, contained no documented evidence that the signed-out doses of [MEDICATION NAME] were actually administered to the resident on those dates. Interview with the Director of Nursing on August 26, 2020, at 1:25 p.m. confirmed that there was no documented evidence that the doses of [MEDICATION NAME] that were signed-out were actually administered to Resident 14 on the above dates. physician's orders [REDACTED]. However, the resident's clinical record, including the MAR, contained no documented evidence that the signed-out doses of [MEDICATION NAME] were actually administered to the resident on those dates. Interview with the Director of Nursing on August 27, 2020, at 2:15 p.m. confirmed that there was no documented evidence that the doses of [MEDICATION NAME] that were signed-out were actually administered to Resident 77 on the above dates. 28 Pa. Code 211.9(h) Pharmacy services. 28 Pa. Code 211.12(d)(1)(5) Nursing services.
F 0758 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of policies and clinical records, as well as staff interviews, it was determined that the facility failed to ensure that a gradual dose reduction was attempted for one of 41 residents reviewed (Resident 31) who received [MEDICAL CONDITION] medication (any medication that affects brain activities associated with mental processes and behavior). Findings include: The facility's policy regarding medication utilization, dated December 31, 2019, indicated that the consulting pharmacist should use the monthly drug regimen review to help identify potentially problematic medications, and advise the physician and staff about options to address medication-related issues. physician's orders [REDACTED]. The physician responded to the recommendation by placing a checkmark in front of the continue as needed box and wrote in lower dose. A corresponding physician's orders [REDACTED]. There was no documented evidence that staff transcribed the order to decrease the [MEDICATION NAME] from 2 mg to 1 mg (half a tablet) into the electronic record, and Resident 31's Medication Administration Record [REDACTED]. Interview with the Director of Nursing on August 26, 2020, at 5:45 p.m. confirmed that the April 27, 2020, physician's orders [REDACTED]. 28 Pa. Code 211.12(d)(3) Nursing services.
F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of policies and clinical records, as well as observations and resident and staff interviews, it was determined that the facility failed to maintain clinical records that were complete and accurately documented for three of 41 residents reviewed (Residents 11, 14, 77). Findings include: The facility's policy regarding medication administration, dated December 31, 2019, indicated that the individual who administered the medication must initial the resident's Medication Administration Record (MAR) on the appropriate line after giving each medication and before administering the next medications. As required or indicated for a medication, the individual who administered the medication was to record the date and time the medication was administered in the resident's medical record, and was to document their signature and title. physician's orders [REDACTED]. physician's orders [REDACTED]. Resident 11's MAR for August 2020 indicated that staff administered a dose of [MEDICATION NAME] on August 24, 2020, at 5:08 a.m. However, the resident's controlled medication sign-out sheet (a form used to account for each dose of a controlled medication) for that date did not indicate that the 5:08 a.m. dose was removed from the resident's supply. Resident 11's controlled medication sign-out sheet for August 2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395500	A. BUILDING _____ B. WING _____	**08/27/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
TWIN LAKES REHABILITATION AND HEALTHCARE CENTER	**227 SAND HILL ROAD GREENSBURG, PA 15601**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 3) indicated that a dose of [MEDICATION NAME] was signed-out for administration on August 7, 2020, at 9:45 p.m. However, the resident's MAR indicated that the [MEDICATION NAME] was administered on August 7, 2020, at 10:45 p.m. Interview with the Director of Nursing on August 27, 2020, at 2:15 p.m. confirmed that there was no documented evidence that the dose of [MEDICATION NAME] that was documented as administered on Resident 11's MAR was not signed out on the resident's controlled medication sign-out sheet on August 24, 2020. She also confirmed that there should not be a time difference when signing out a medication on a resident's controlled medication sign-out sheet and the time of administration on the resident's MAR. physician's orders [REDACTED]. Resident 14's controlled medication sign-out sheet for July 2020 indicated that a dose of [MEDICATION NAME] was signed-out for administration on July 18, 2020, at 8:00 a.m. and July 31, 2020, at 9:00 p.m. However, the resident's MAR indicated that the [MEDICATION NAME] was administered on July 18, 2020, at 10:13 a.m. and July 31, 2020, at 10:32 p.m. Resident 14's controlled medication sign-out sheet for August 2020 indicated that a dose of [MEDICATION NAME] was signed-out for administration on August 1, 2020, at 9:00 a.m.; August 3, 2020, at 8:00 a.m.; August 8, 2020, at 9:00 p.m.; August, 21, 2020, at 7:30 p.m.; and August 26, 2020, at 8:55 a.m. However, the resident's MAR indicated that the [MEDICATION NAME] was administered on August 1, 2020, at 10:13 a.m.; August 3, 2020, at 7:21 a.m.; August 8, 2020, at 10:25 p.m.; August 21, 2020, at 8:07 p.m.; and August 26, 2020, at 7:54 a.m. Interview with the Director of Nursing on August 26, 2020, at 1:25 p.m. confirmed that there should not be a time difference when signing out the medication on Resident 14's controlled medication sign-out sheets and the time of administration on the resident's MAR. physician's orders [REDACTED]. Resident 77's MAR for August 2020 indicated that staff administered a dose of [MEDICATION NAME] on August 12, 2020, at 6:00 a.m. However, the resident's controlled medication sign-out sheet for that date did not indicate that the 6:00 a.m. dose was removed from the resident's supply. Interview with the Director of Nursing on August 27, 2020, at 2:15 p.m. confirmed that there was no documented evidence that the dose of [MEDICATION NAME] that was documented on the MAR as being given on August 12, 2020, at 6:00 a.m. was not signed-out on the resident's controlled medication sign-out sheet. 28 Pa. Code 211.5(f) Clinical records. 28 Pa. Code 211.12(d)(5) Nursing services.
F 0867 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the facility's plans of correction for previous surveys, and the results of the current survey, it was determined that the facility's Quality Assurance Performance Improvement (QAPI) committee failed to maintain compliance with quality deficiencies and ensure that plans to improve the delivery of care and services effectively addressed recurring deficiencies. Findings include: The facility's deficiencies and plans of correction for a State Survey and Certification (Department of Health) survey ending February 12, 2020, revealed that the facility developed plans of correction that included quality assurance systems to ensure that the facility maintained compliance with cited nursing home regulations. The results of the current survey, ending August 27, 2020, identified repeated deficiencies related to failures to complete an assessment to determine the resident's capacity for self-administration of medications, to ensure that a professional (registered) nurse performed an assessment when required, to ensure that the resident's environment remained free from accident hazards, and to ensure that [MEDICAL CONDITION] medications were not used unnecessarily. The facility's plan of correction for a deficiency regarding a failure to complete an assessment to determine the resident's capacity for self-administration of medications, cited during the survey ending February 12, 2020, revealed that the facility would complete audits and the results would be reviewed as part of quality assurance. The results of the current survey, cited under F554, revealed that the facility's QAPI committee was ineffective in maintaining compliance with the regulation regarding completing assessments to determine the resident's capacity for self-administration of medications. The facility's plan of correction for a deficiency regarding a failure to ensure that a professional (registered) nurse performed an assessment when required, cited during the survey ending February 12, 2020, revealed that the facility would complete audits and the results would be reviewed as part of quality assurance. The results of the current survey, cited under F658, revealed that the facility's QAPI committee was ineffective in maintaining compliance with the regulation regarding maintaining acceptable standards of quality. The facility's plan of correction for a deficiency regarding ensuring that the resident environment remained free from accident hazards, cited during the survey ending February 12, 2020, revealed that audits would be completed. The results of the current survey, cited under F689, revealed that the QAPI committee was ineffective in correcting deficient practices related to ensuring that the resident environment remained free from accident hazards. The facility's plan of correction for a deficiency regarding a failure to ensure that [MEDICAL CONDITION] medications were not used unnecessarily, cited during the survey ending February 12, 2020, revealed that the facility would complete audits and the results would be reviewed as part of quality assurance. The results of the current survey, cited under F758, revealed that the facility's QAPI committee was ineffective in maintaining compliance with the regulation regarding ensuring that [MEDICAL CONDITION] medications were not used unnecessarily. Refer to F554, F658, F689, F758. 28 Pa. Code 201.14(a) Responsibility of licensee. 28 Pa. Code 201.18(e)(1) Management.