

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395041	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/12/2025
NAME OF PROVIDER OR SUPPLIER Twinbrook Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3805 Field Street Erie, PA 16511	

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)
<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>Based on review of facility policy, facility documents, and clinical records, and staff interviews, it was determined that the facility failed to have sufficient staff with the appropriate skill sets to provide nursing services.</p> <p>Findings include:</p> <p>A facility policy entitled Nursing Services and Sufficient Staff dated 11/8/24, indicated, The facility will supply services by sufficient numbers of each of the following personnel types on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans . Providing care includes, but is not limited to, assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.</p> <p>Review of Resident R1's clinical record and documentation for 5/25/25, revealed that Resident R1 was ordered an enteral feeding (method of providing nutrition directly to the stomach through a tube) to be started at 4:00 p.m. and Lispro Insulin (medication to control blood sugar levels) before meals. The May 2025 Medication Administration Record (MAR) revealed that the feeding was not started until 9:42 p.m. and the Lispro Insulin ordered before dinner at 5:00 p.m. was not administered until 9:42 p.m.</p> <p>Review of Resident R2's clinical record and documentation for 5/25/25, revealed that Resident R2 was ordered an enteral feeding to be started at 4:00 p.m. The May 2025 MAR revealed that the feeding was not started until 10:24 p.m.</p> <p>Review of Resident R3's clinical record and documentation for 5/25/25, revealed that Resident R3 was ordered an enteral feeding to be started at 6:00 p.m. The May 2025 MAR indicated the feeding was not started until 7:46 p.m.</p> <p>During an interview with Registered Nurse (RN) Employee E1 on 5/29/25, at 12:05 p.m. revealed that on 5/25/25, at the time of shift change he/she was the only nurse for the 3:00 p.m.-11:00 p.m. shift from 4:00 p.m. to 7:00 p.m. and he/she was responsible for all the medication cart keys. RN Employee E1 confirmed that there was a significant delay in medication administration times related to short staffing.</p> <p>(continued on next page)</p>

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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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview with Licensed Practical Nurse (LPN) Employee E2 on 5/29/25, at 11:45 a.m. revealed that there were concerns with staffing levels on 5/25/25. He/she confirmed that there was not enough nursing staff in the facility on 5/25/25, which caused a significant delay in medication administration.</p> <p>Staff Interview conducted with LPN Employee E3 on 5/29/25, at 11:25 a.m. revealed that on 5/25/25, he/she worked the 7:00 a.m.-3:00 p.m. shift and during shift change for the 3:00 p.m.-11:00 p.m. shift there was only one nurse for the entire building. He/she confirmed that there was a significant delay in medication administration times related to short staffing.</p> <p>During an interview on 6/11/25, at approximately 1:50 p.m. the Nursing Home Administrator confirmed that the facility's nursing staff shortages on 5/25/25, led to a significant delay in medication administration for Resident R1 and a delay starting enteral feedings for Residents R1, R2, and R3.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code 211.12(d)(1)(4)(5) Nursing services</p> <p>28 Pa. Code 211.12 (f.1)(4) Nursing services</p>