| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 395041 | A. Building<br>B. Wing | 03/10/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Twinbrook Healthcare and Rehabilitation Center | 3805 Field Street<br>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) |
|---|---|
| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.<br><br>Based on review of facility policy, clinical records, and staff interviews, it was determined that the facility failed to ensure the physician was notified timely regarding laboratory studies for one of four residents reviewed (Resident R2).Findings include: A facility policy, Change in a Resident's Condition, dated 2/02/26, revealed Our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.). Resident R2' s clinical record revealed an admission date of 1/22/22, with diagnoses that included Alzheimer's (a disease of the brain affecting mood, behavior, and decision making), atrial flutter (a type of fast heart rhythm where the heart's upper chambers, the atria, beat rapidly in a regular pattern), muscle weakness, and high blood pressure. Resident R2's clinical record revealed a lab finding report dated as - collected 11/26/25, received 11/27/25, reported 11/27/25, with an abnormal potassium level. Progress notes revealed that on 12/11/25, Resident R2's abnormal potassium findings were reviewed with the physician, and he/she was then transferred to the hospital related to his/her potassium level obtained on 11/26/25. The facility lacked evidence that the physician was notified timely regarding the abnormal potassium level. During an interview on 3/04/26, at 2:55 p.m. the Assistant Director of Nursing confirmed that the facility lacked evidence that the physician was notified timely in regard to the abnormal potassium level, and a lack of immediate physician notification for Resident R2's change in condition regarding his/her abnormal potassium level obtained on 11/26/25. 28 Pa. Code 211.12(d)(1) Nursing services 28 Pa. Code 211.12(d)(5) Nursing services |

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 |
|---|---|---|

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 395041 | A. Building<br>B. Wing | 03/10/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Twinbrook Healthcare and Rehabilitation Center | 3805 Field Street<br>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) |
|---|---|
| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide enough food/fluids to maintain a resident's health.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy and clinical records, observations, and staff interviews, it was determined that the facility failed to ensure adequate assistance and supervision with meals was provided for one of four residents observed in the [NAME] Dining Room (Resident R1); failed to ensure assessment of a resident's nutritional status on admission and as needed thereafter and failed to complete a comprehensive nutritional assessment for a resident identified as being at risk for unplanned weight loss and/or compromised nutritional status for five of 26 residents (Residents R3, R4, R5, R6, and R7); and failed to ensure nutritional interventions were implemented for two of 26 residents reviewed (Residents R8 and R9). Findings include: A facility policy dated 2/02/26, entitled Weight Monitoring and Nutritional Assessment, revealed policy statement - to maintain acceptable parameters of nutritional status, the facility shall establish a consistent process for weighing residents and conducting nutritional assessments under the direction of a Registered Dietitian. The goal is to identify and address significant weight changes and ensure residents receive therapeutic diets tailored to their clinical needs. Procedures for weight monitoring - initial baseline - nursing staff will weigh each resident upon admission or readmission to establish a baseline weight. Routine frequency - new admissions - weekly for the first four weeks. Ongoing - at least monthly thereafter, unless a more frequent schedule is clinically indicated. Verification - any weight change of 5 % or more in one month must be re-taken to confirm accuracy. The Registered Dietitian (RD) responsibilities - Assessment intervals - The RD will complete a comprehensive nutritional assessment within 14 days of admission and periodically (quarterly/annually) to coincide with MDS (Minimum Data Set) schedules. High risk monitoring - residents identified as high risk (e.g., significant weight loss, tube feeding, or wounds) will receive a monthly nutrition review by the RD. Notification and Intervention - The RD will update the interdisciplinary team to evaluate the cause and update the care plan with new interventions (e.g., supplements, diet texture and changes). Documentation - All assessments, weight trends, and physician notifications must be clearly documented in the resident's medical record. A facility policy dated 2/02/26, entitled Resident Dining Support and Dining Services revealed to ensure all residents receive adequate assistance with meals and personalized nutritional support in accordance with Pennsylvania state regulations, fostering independence, optimal nutrition, and resident dignity. Resident Assistance standards - physical support - staff shall provide physical assistance with eating for any resident whose assessment or support plan indicates a need. Supplemental snacks and hydration - supplemental administration - if a resident is ordered a nutritional supplement (e.g., Ensure, Glucerna), it must be provided and documented as part of the medical or dietary record. Resident R1's clinical record revealed an admission date of 1/19/22, with diagnoses that included cerebrovascular accident (CVA - a stroke when blood flow to the brain is stopped or slowed causing damage to the brain tissue), right sided hemiplegia (a severe form of one sided weakness of right side of body caused by brain damage), dysphagia (difficulty swallowing) and depression. Resident R1's clinical record, Kardex (a brief overview of a resident's plan of care) dated 3/03/26, provided by Speech Therapist Employee E1 on 3/03/26, revealed Eating/Nutrition: The resident needs Supervision due history of pocketing food. Resident R1's Activities of Daily Living (ADLs) care plan provided on 3/03/26, revealed Resident R1 requires assist with activities of daily living related to impaired balance and hemiplegia with contractures of right upper extremities, and Resident R1 needs supervision with eating due to history of pocketing food. Observations on 3/03/26, at 12:10 p.m. and 12:20 p.m. with the Social Worker, revealed Resident R1 eating his/her lunch meal with no staff present for supervision or assistance. Speech Therapist Employee E1 confirmed on 3/03/26, at 1:30 p.m. that Resident R1 requires staff supervision with eating due to history of pocketing food and should have had staff present during the lunch meal due to history of pocketing food and diagnosis of dysphagia. Resident R3's clinical record revealed an admission date of 7/22/25, (continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 395041 | A. Building<br>B. Wing | 03/10/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Twinbrook Healthcare and Rehabilitation Center | 3805 Field Street<br>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) |
|---|---|
| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | with diagnoses that included muscle wasting and atrophy (loss of muscle tissue resulting in reduced strength), morbid obesity (a disease involving having too much body fat), unstageable pressure ulcer (a full thickness wound where the depth cannot be determined due wound bed is covered by necrotic tissue making it impossible to see the depth of wound), and depression. Resident R3's clinical record revealed weights obtained for dates 12/09/25, as 236.7 pounds, 2/05/26, as 242.8 pounds, and 3/03/26, as 211.0 pounds. Resident R3's clinical record lacked any evidence of a nutritional assessment being completed after 12/08/25, with above noted weight loss. Resident R4's clinical record revealed an admission date of 7/07/21, with diagnoses that included diabetes (a health condition caused by the body's inability to produce enough insulin), morbid obesity, muscle weakness, and depression. Resident R4's clinical record revealed weights obtained for dates 12/09/25, as 209.8 pounds, 2/11/26, as 190.0 pounds, and 3/03/26, as 192.4 pounds. Resident R4's clinical record lacked any evidence of a nutritional assessment being completed after 12/08/25, with above noted weight loss. Resident R5's clinical record revealed an admission date of 10/15/18, with diagnoses that included ischemic cardiomyopathy (a disease of the heart muscle where the weakened, enlarged heart muscle cannot pump well due to damage from a lack of blood supply), heart failure (a chronic condition where the heart cannot pump blood efficiently), chronic obstructive pulmonary disease (COPD - a condition that prevents airflow to the lungs resulting in difficulty breathing), and muscle weakness. Resident R5's clinical record revealed weights obtained for dates 8/07/25, 118.8 pounds, 12/09/25, as 109.2 pounds, 2/11/26, as 104.6 pounds, 2/17/26, hospital weight 103.0 and 3/03/26, as 102.8 pounds. Resident R5's clinical record lacked any evidence of a nutritional assessment being completed after 8/11/25, with above noted weight loss. Resident R6's clinical record revealed an admission date of 1/01/26, with diagnoses that included respiratory failure (a condition where you don't get enough oxygen or you get too much carbon dioxide in your body), heart failure, flu, and high blood pressure. Resident R6's clinical record revealed weights obtained for dates 1/01/26, 189.0, and 3/07/26, 178.2. Resident R6's clinical record lacked any evidence of a comprehensive nutritional assessment being completed after admission and/or throughout his/her stay at the facility at this time. Resident R7's clinical record revealed an admission date of 6/29/25, with diagnoses that included muscle wasting and atrophy, arthritis, repeated falls, and muscle weakness. Resident R7's clinical record revealed weights obtained for dates 11/01/25, 264.5, and 3/03/26, 238.4. Resident R7's clinical record lacked any evidence of a nutritional assessment being completed after 10/06/25, with above noted weight loss. Resident R8's clinical record revealed an admission date of 3/14/24, with diagnoses that included schizoaffective/bilpolar disorder (a mental health condition combining hallucinations, delusions, disorganized thinking with severe mood swings), heart failure, respiratory failure, and morbid obesity. Resident R8's clinical record revealed a nutritional assessment dated [DATE], that indicated there had been a 9.2% weight change within the past 180 days - not significant. Weights have been stable around 230 pounds the past six months and have shown a 20 pound weight decrease in the past month. Further recommendation Unsure if most recent wt. is an error, will have staff reweigh. The facility lacked evidence of a reweigh. Resident R9's clinical record revealed an admission date of 2/26/25, with diagnoses that included COPD, heart failure, muscle weakness, and history of a fall. Resident R9's clinical record revealed a nutritional assessment dated [DATE], indicated weight warning: 146.2 pounds obtained on 2/01/26, weight noted as unplanned significant loss x 30 days. Resident currently receives 2 p.m. snack as per his preference. Will add to meal plan House Shake at dinner with notification of Dietary Department this date. The facility lacked evidence of the House Shake being added to Resident R9's meal plan or orders. During an interview on 3/09/26, at 1:20 p.m. the Nursing Home Administrator (NHA) confirmed there was no documented nutritional assessments for the above identified residents on admission or thereafter as required. The NHA further confirmed the facility failed to ensure staff supervision with meals was provided for Resident R1, and recommended interventions following a nutritional assessment were not completed for Residents R8 and R9. 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.10(c) Resident care policies 28 Pa. Code 211.12(d)(1) Nursing services 28 Pa. Code 211.12(d)(5) Nursing services |