STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395041	A. Building B. Wing	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Twinbrook Healthcare and Rehabilitation Center	3805 Field Street Erie, PA 16511

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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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on review of facility policy, clinical records, and staff interviews it was determined that the facility failed to provide the resident and/or resident representative with a written notice of the facility bed-hold policy (explanation of how long a bed can be held during a leave of absence and the cost per day), and failed to make certain that the necessary resident information was communicated to the receiving health care provider upon transfer to the hospital for nine of 28 residents reviewed (Residents R5, R7, R8, R15, R17, R84, R94, R105, and R109).Findings include:Review of facility policy entitled Transfer and Discharge dated 2/2/26, indicated For a transfer to another provider, for any reason, the following information must be provided to the receiving provider:Contact information of the practitioner who was responsible for the care of the resident;Resident representative information, including contact information;Advance directive information;All other information necessary to meet the resident's needs, which includes, but may not be limited to:Resident status, including baseline and current mental, behavioral, and functional status, reason for transfer, recent vital signs;Diagnoses and allergies;Medications (including when last received); andMost recent relevant labs, other diagnostic tests and recent immunizations.All special instructions and/or precautions for ongoing care, as appropriate.The resident's comprehensive care plan goals;All other information necessary to meet the resident's needs.Review of Resident R5's clinical record revealed an admission date of 12/19/23, with diagnoses that included chronic obstructive pulmonary disease (when your lungs do not have adequate air flow), chronic congestive heart failure (a condition where the heart cannot supply the body with enough blood), and hypertension (high blood pressure).Review of Resident R5's progress notes revealed notes dated 9/22/25, and 2/4/26, indicating transfers to the hospital. The clinical record lacked evidence that his/her necessary clinical information was communicated to the receiving health care provider. His/her clinical record also lacked evidence indicating that he/she and/or his/her representative were provided with a copy of the bed-hold policy upon transfers on 9/22/25, and 2/4/26. Resident R7's clinical record revealed an admission date of 8/16/22, with diagnoses that included chronic kidney disease (a long-term condition in which the kidneys are damaged and gradually lose their ability to function properly over time, gastro-esophageal reflux disease (GERD - a condition where stomach acid flows back into the esophagus (tube that passes food from the mouth into the stomach), and hypertension.Review of Resident R7's progress notes revealed a note dated 4/1/26, indicating a transfer to the hospital. The clinical record lacked evidence that his/her necessary clinical information was communicated to the receiving health care provider. His/her clinical record also lacked evidence indicating that he/she and/or his/her representative were provided with a copy of the bed-hold policy upon transfer on 4/1/26. Review of Resident R8's clinical record revealed an admission date of 11/16/20, with diagnoses that included dependence of renal dialysis (a treatment that helps remove extra fluid and waste products from the blood when the kidneys are not able to), diabetes (a health condition that is caused by the body's inability to produce enough insulin), and gastro-esophageal reflux disease.Review of Resident R8's progress notes revealed notes dated 11/19/25, and 2/3/26, indicating transfers to the hospital. The clinical record lacked evidence that his/her necessary clinical information was communicated to the receiving health (continued on next page)

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	care provider. His/her clinical record also lacked evidence indicating that he/she and/or his/her representative were provided with a copy of the bed-hold policy upon transfers on 11/19/25, and 2/3/26. Review of Resident R15's clinical record revealed an admission date of 7/7/22, with diagnoses that included chronic obstructive pulmonary disease, gastro esophageal reflux disease, and chronic respiratory failure (a condition where your lungs don't exchange air properly).Review of Resident R15's progress notes revealed a note dated 2/3/26, indicating a transfer to the hospital. The clinical record lacked evidence that his/her necessary clinical information was communicated to the receiving health care provider. His/her clinical record also lacked evidence indicating that he/she and/or his/her representative were provided with a copy of the bed-hold policy upon transfer on 2/3/26. Review of Resident R17's clinical record revealed an admission date of 2/26/25, with diagnoses that included diabetes, muscle weakness, and toe amputation.Review of Resident R17's progress notes revealed notes dated 10/25/25, indicating a transfer to the hospital. The clinical record lacked evidence that his/her necessary clinical information was communicated to the receiving health care provider. His/her clinical record also lacked evidence indicating that he/she and/or his/her representative were provided with a copy of the bed-hold policy upon transfer on 10/25/25. Review of Resident R84's clinical record revealed an admission date of 6/28/22, with diagnoses that included dysphagia (difficulty swallowing), muscle weakness, and difficulty walking.Review of Resident R84's progress notes revealed notes dated 9/7/25, indicating a transfer to the hospital. The clinical record lacked evidence that his/her necessary clinical information was communicated to the receiving health care provider. His/her clinical record also lacked evidence indicating that he/she and/or his/her representative were provided with a copy of the bed-hold policy upon transfer on 9/7/25. Review of Resident R94's clinical record revealed an admission date of 2/17/26, with diagnoses that included gastrointestinal hemorrhage (excessive bleeding in the digestive tract), hypertension, and transient ischemic attack and cerebral infraction (also known as a stroke it occurs when blood flow to part of the brain is blocked).Review of Resident R94's progress notes revealed notes dated 2/24/26, 3/19/26, and 4/13/26, indicating transfers to the hospital. The clinical record lacked evidence that his/her necessary clinical information was communicated to the receiving health care provider. His/her clinical record also lacked evidence indicating that he/she and/or his/her representative were provided with a copy of the bed-hold policy upon transfers on 2/24/26, 3/19/26, and 4/13/26. Review of Resident R105's clinical record revealed and admission date of 12/16/24, with diagnoses that included dementia (a disease that affects short term memory and the ability to think logically), depression, and muscle weakness.Review of Resident R105's progress notes revealed notes dated 3/29/26, and 4/14/26, indicating transfers to the hospital. The clinical record lacked evidence that his/her necessary clinical information was communicated to the receiving health care provider. His/her clinical record also lacked evidence indicating that he/she and/or his/her representative were provided with a copy of the bed-hold policy upon transfers on 3/29/26, and 4/14/26. Resident R109's clinical record revealed an admission date of 3/23/26, with diagnoses that included cellulitis (bacterial infection affecting deeper layers of the skin), hypertension, and dorsalgia (back pain).Review of Resident R109's progress notes revealed notes dated 3/31/26, indicating a transfer to the hospital. The clinical record lacked evidence that his/her necessary clinical information was communicated to the receiving health care provider. His/her clinical record also lacked evidence indicating that he/she and/or his/her representative were provided with a copy of the bed-hold policy upon transfer on 3/31/26. During an interview on 4/15/26, at 2:00 p.m. the Director of Nursing (DON) confirmed that Residents R5, R7, R8, R15, R17, R84, R94, R105, and R109's clinical records lacked evidence that the necessary clinical information was provided to the receiving healthcare provider and lacked evidence indicating that he/she and/or his/her representative were provided with a copy of the bed-hold policy upon transfer. The DON also confirmed when the transfers occurred clinical information should have been provided to the receiving healthcare provider and bed hold policy should have been provided to the resident/representative upon transfer. 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 201.29(c.3) (2) Resident rights

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted Based on review of facility policy, clinical records, and staff interview, it was determined that the facility failed to provide a written summary of the baseline care plan and order summary to the resident and/or representative for six of 28 residents reviewed (Residents R1, R10, R55, R56, R94, and R109).Findings include:Review of facility policy entitled Baseline Care Plan dated 2/2/26, revealed The person providing the written summary of the baseline care plan shall:Obtain a signature from the resident/representative to verify that the summary was provided.Make a copy of the summary for the medical record.Resident R1's clinical record revealed an admission date of 12/23/25, with diagnoses that included hemiplegia (a condition where a person is paralyzed and unable to move one side of their body), hypertension (high blood pressure), and diabetes (a health condition that is caused by the body's inability to produce enough insulin)Resident R1's clinical record lacked evidence that a written summary of the baseline care plan and order summary was provided to Resident R1 and/or his/her representative. Resident R10's clinical record revealed an admission date of 2/20/26, with diagnoses that included solitary pulmonary nodule (a small round or oval shaped spot in the lung), pain, and retroperitoneal hematoma (an accumulation of blood behind the abdominal cavity).Resident R10's clinical record lacked evidence that a written summary of the baseline care plan and order summary was provided to Resident R10 and/or his/her representative. Resident R55's clinical record revealed an admission date of 1/6/26, with diagnoses that included chronic kidney disease (a long-term condition in which the kidneys are damaged and gradually lose their ability to function properly over time), low back pain, and hypertension.Resident R55's clinical record lacked evidence that a written summary of the baseline care plan and order summary was provided to Resident R55 and/or his/her representative. Resident R56's clinical record revealed an admission date of 1/6/26, with diagnoses that included Chronic Obstructive Pulmonary Disease (COPD - a condition that prevents airflow to the lungs resulting in difficulty breathing), Atrial Fibrillation (A-Fib - irregular and often rapid heartbeat that can lead to stroke, heart failure, and other complications), and hypertension.Resident R56's clinical record lacked evidence that a written summary of the baseline care plan and order summary was provided to Resident R56 and/or his/her representative. Resident R94's clinical record revealed an admission date of 2/17/26, with diagnoses that included gastrointestinal hemorrhage (excessive bleeding in the digestive tract), hypertension, transient ischemic attack and cerebral infraction (also known as a stroke it occurs when blood flow to part of the brain is blocked).Resident R94's clinical record lacked evidence that a written summary of the baseline care plan and order summary was provided to Resident R94 and/or his/her representative. Resident R109's clinical record revealed an admission date of 3/23/26, with diagnoses that included cellulitis (bacterial infection affecting deeper layers of the skin), hypertension, and dorsalgia (back pain).Resident R109's clinical record lacked evidence that a written summary of the baseline care plan and order summary was provided to Resident R109 and/or his/her representative.During an interview on 4/15/26, at 2:53 p.m. the Assistant Director of Nursing confirmed there was no evidence that a written summary of the baseline care plan and order summary were provided to Residents R1, R10, R55, R56, R94, and R109 and/or their representatives.28 Pa. Code 211.10(c) Resident care policies28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. Based on review of facility policy and clinical records, observations, and staff interview, it was determined that the facility failed to provide oxygen according to physician's orders and failed to promote cleanliness and help prevent the spread of infection regarding respiratory care equipment for three residents reviewed with respiratory care (Residents R1, R5, and R15).Findings include: Review of facility policy dated 2/2/26, entitled Oxygen Administration indicated Oxygen is administered under orders of a physician. and Clean/rinse O2 concentrator filter weekly. Review of Resident R1's clinical record revealed an admission date of 12/23/25, with diagnoses that included hemiplegia (a condition where a person is paralyzed and unable to move one side of their body), hypertension (high blood pressure), and diabetes (a health condition that is caused by the body's inability to produce enough insulin). Review of Resident R1's physician orders revealed orders dated 12/23/25, for oxygen at four L/min (liters/minute) via nasal cannula (a thin tube with two prongs that fit into the resident's nostrils to deliver oxygen) every shift and to clean O2 (oxygen) concentrator filter every night shift on Tuesdays. Review of Resident R1's care plan revealed a care plan for respiratory impairment with an intervention for oxygen as per physician orders. Observations on 4/13/26, at 1:09 p.m. and again at 2:35 p.m. revealed Resident R1 lying in his/her bed with supplemental oxygen in place and the oxygen concentrator liter flow set at three L/min. Further observations of the oxygen concentrator filters to bilateral sides of the oxygen concentrator revealed no filters on the oxygen concentrator where the filters should be located. Review of Resident R5's clinical record revealed an admission date of 12/19/23, with diagnoses that included chronic obstructive pulmonary disease (when your lungs do not have adequate air flow), diabetes, and chronic respiratory failure (a condition where your lungs don't exchange air properly). Review of Resident R5's physician orders revealed orders dated 2/6/26, for oxygen at two L/min every shift and to clean O2 (oxygen) concentrator filter every night shift on Tuesdays. Review of Resident R5's care plan revealed a care plan for respiratory impairment with an intervention for oxygen as per MD (medical doctor) orders. Observations on 4/13/26, at 1:09 p.m. and again at 2:35 p.m. revealed Resident R5 lying in his/her bed with supplemental oxygen in place and the oxygen concentrator liter flow set at three L/min. Observation of the concentrator filters to bilateral sides of the oxygen concentrator revealed a large amount of gray fluffy substance covering bilateral filters. Review of Resident R15's clinical record revealed an admission date of 7/7/22, with diagnoses that included chronic obstructive pulmonary disease, gastro esophageal reflux disease (a condition when stomach acid repeatedly flows back into your throat), and chronic respiratory failure. Review of Resident R15's physician orders revealed orders dated 7/24/25, for oxygen at 4 L/min via nasal cannula every shift and to clean O2 concentrator filter every night shift on Tuesdays. Review of Resident R15's care plan revealed a care plan for respiratory impairment with an intervention to provide O2 maintenance per MD orders. Observations on 4/13/26, at 1:04 p.m. and again at 2:37 p.m. revealed Resident R15 lying in his/her bed with supplemental oxygen in place and the oxygen concentrator liter flow set at 2 L/min. Observation of the concentrator filter to the back of the oxygen concentrator revealed a large amount of gray fluffy substance covering the filter. During an interview on 4/13/26, at 2:40 p.m. Registered Nurse Employee E3 confirmed that Resident R1's oxygen flow rate was set at 3 L/min, Resident R5's oxygen flow rate was set at 3 L/min, Resident R15's oxygen flow rate was set at 2 L/min and they were not in accordance with the physician's orders. He/she also confirmed that Resident R5's oxygen concentrator did not have filters in place, and Resident R1 and R15's oxygen concentrator filters were covered in a gray fluffy substance, and the filters should be clean per physician orders. 28 Pa. Code 211.10(c) Resident care policies 28 Pa. Code 211.12(d)(1)(5) Nursing services

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, manufacturer's guidelines, observations, and staff interviews, it was determined that the facility failed to ensure that medications were properly dated when opened and failed to ensure an expired medication was discarded in a timely manner in two of three medication carts reviewed (East Two Cart and South Cart). Findings include: Review of a facility policy entitled Medication Administration dated [DATE], revealed that, Check expiration date on package/container. No expired medication will be administered to a resident .Injectable multi-dose vials: 28 days after open date or per manufacturer's guidelines. Manufacturer's guidelines for Fluticasone Propionate and Salmeterol Powder (an inhaler used long-term for individuals with breathing problems), indicated that the use by date is one month after the inhaler is opened. Manufacturer's guidelines for Humalog insulin (a fast-acting insulin used to manage blood sugar levels in people with diabetes), indicated that after opened vials and pre-filled pens should be discarded after 28 days. Manufacturer's guidelines for Lantus insulin (a long-acting insulin used to manage blood sugar levels in people with diabetes), indicated that after opened vials and pre-filled pens should be discarded after 28 days. Observation on [DATE], at 12:52 p.m. of the East Two medication cart revealed an open Fluticasone Propionate and Salmeterol Powder inhaler without an open date, therefore staff were unable to determine the discard date. During an interview at that time, Licensed Practical Nurse (LPN) Employee E1 confirmed that the Fluticasone Propionate and Salmeterol Powder inhaler lacked an open date. Observation on [DATE], at 2:37 p.m. of the South medication cart revealed an open injector pen of Humalog insulin with an open date of [DATE], therefore the medication was expired; and two open injector pens of Lantus insulin without an open date, therefore staff were unable to determine the discard date. During an interview at that time LPN Employee E2 confirmed that the injector pen of Humalog insulin expired and should have been discarded, and that the two injector pens of Lantus insulin lacked an open date. 28 Pa. Code 211.9(a)(1) Pharmacy services 28 Pa. Code 211.10(c) Resident care policies 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on review of facility policies, clinical records, and staff interview, it was determined that the facility failed to provide a clinical rationale for the continued use of a PRN (as needed) psychotropic (affecting the mind) medication beyond 14-days and failed to provide evidence that non-pharmacological interventions (interventions attempted to calm a resident other than medication) were attempted prior to the administration of an as needed (PRN) psychotropic (mind altering) medication for two of 28 residents reviewed (Residents R10 and R56).Findings include: A facility policy entitled Medication Management dated 2/2/26, revealed .The facility's medication management supports and promotes.The use of non-pharmacological approaches, unless contraindicated, to minimize the need for medications, permit use of the lowest possible dose, or allow medications to be discontinued. A facility policy entitled Stop Orders For Acute Conditions dated 2/2/26, revealed The following classes of medications will not automatically be refilled after the indicated number of days . PRN psychotropic medications (14 days). Resident R10's clinical record revealed an admission date of 2/20/26, with diagnoses that included solitary pulmonary nodule (a small round or oval shaped spot in the lung), pain, and retroperitoneal hematoma (an accumulation of blood behind the abdominal cavity). Review of Resident R10's clinical record revealed a physician's order dated 2/23/26, identified to administer Lorazepam (anti-anxiety) oral tablet 1 milligram (mg) give 0.5 tablet by mouth every four hours PRN. The order did not have a stop date. The clinical record lacked the required clinical rationale for continued use beyond 14 days. Review of Resident R10's clinical record revealed a physician's order dated 4/4/26, identified to administer Haloperidol (anti-psychotic) oral concentrate a 0.5 ml (milliliters) by mouth every 4 hours PRN. The order did not have a stop date. The clinical record lacked the required clinical rationale for continued use beyond 14 days. Review of Resident R10's February 2026, March 2026, and April 2026 Medication Administration Record (MAR) revealed that the PRN Lorazepam was used on 2/23/26, 2/24/26, 2/25/26, 2/26/26, 3/6/26, 3/8/26, 3/10/26, 3/11/26, 3/12/26, 3/14/26, 3/16/26, 3/17/26, 3/18/26, 3/24/26, and 4/9/26; the as needed Haloperidol was used on 4/4/26. The clinical record lacked evidence of non-pharmacological interventions being attempted prior to the administration of the PRN Lorazepam for the four administrations in February 2026, for the 10 administrations in March 2026, and for the one administration in April 2026. The clinical record lacked evidence of non-pharmacological interventions being attempted prior to the administration of the PRN Haloperidol for the one administration in April 2026. Resident R56's clinical record revealed an admission date of 1/6/26, with diagnoses that included Chronic Obstructive Pulmonary Disease (COPD - a condition that prevents airflow to the lungs resulting in difficulty breathing), Atrial Fibrillation (A-Fib - irregular and often rapid heartbeat that can lead to stroke, heart failure, and other complications), and high blood pressure. Resident R56's clinical record revealed a physician's order dated 2/13/26, identified to administer Lorazepam 0.5mg by mouth PRN every four hours. The order did not have a stop date. The clinical record lacked the required clinical rationale for continued use beyond 14 days. Review of Resident R56's MAR from 3/1/26 through 4/15/26 , revealed that the PRN Lorazepam was used daily. The clinical record also lacked evidence of non-pharmacological interventions being attempted prior to the administration of the PRN Lorazepam from 3/1/26 through 4/15/26. During an interview on 4/15/26, at 3:16 p.m. the Director of Nursing confirmed that Resident R10's PRN Lorazepam, Resident R10's PRN Haloperidol, and Resident R56's PRN Lorazepam, lacked the required stop date within 14 days or a clinical rationale for continued use beyond 14 days and that Resident R10 and that Resident R56's clinical records lacked evidence that non-pharmacological interventions were being attempted prior to administering the PRN Lorazepam and PRN Haloperidol. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services

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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. Based on review of facility policy and clinical records and staff interview, it was determined that the facility failed to transcribe a physician order for turning and repositioning for one resident reviewed (Resident R5). Findings include: Review of facility policy entitled Consulting Physician/Practitioner Orders dated 2/2/26, indicated For consulting physician/practitioner orders received in writing. the nurse in a timely manner will:Call the attending physician to verify the orderDocument the verification.Follow facility procedure for verbal or telephone orders including: noting the order. and transcribing to medication or treatment administration record. Review of Resident R5's clinical record revealed an admission date of 12/19/23, with diagnoses that included chronic obstructive pulmonary disease (when your lungs do not have adequate air flow), chronic congestive heart failure (a condition where the heart cannot supply the body with enough blood), and hypertension (high blood pressure). Review of Resident R5's care plan for stage three pressure ulcer revealed an intervention for wound clinic referral and follow up as ordered. Review of Resident R5's visit reports from the wound clinic revealed on 2/12/26, he/she returned with an order for turn and reposition every two hours, avoid direct pressure to wound site. Further review of Resident R5's visit reports from the wound clinic on 2/19/26, 2/27/26, 3/5/26, 3/12/26, 3/19/26, 3/26/26, 4/2/26, and 4/9/26, he/she returned with orders for turn and reposition every two hours, avoid direct pressure to wound site - hip to hip at minimum every two hours. Review of Resident R5's clinical record revealed his/her physician orders lacked evidence that turning and repositioning orders were transcribed into his/her physician orders. Observations on 4/14/26, at 8:00 a.m., 10:55 a.m., 12:10 p.m., and 1:30 p.m. revealed Resident R5 was lying in his/her bed on their back. Observations on 4/15/26, at 9:10 a.m., 11:15 a.m., 12:30 p.m. and 2:35 p.m. Resident R5 was lying in his/her bed on their back. During an interview on 4/16/26, at 10:15 a.m. the Director of Nursing (DON) confirmed that the facility failed to transcribe turning and repositioning orders received from the wound clinic on 2/12/26, 2/19/26, 2/27/26, 3/5/26, 3/12/26, 3/19/26, 3/26/26, 4/2/26, and 4/9/26. The DON also confirmed that Resident R5's turning and repositioning orders should have been transcribed into their physician orders. 28 Pa. Code 211.10(d) Resident care policies 28 Pa. Code 211.12(d)(1)(5) Nursing services

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on review of the facility documents and clinical records, and resident and staff interview, it was determined that the facility failed to maintain complete and accurate records relating to dialysis (a medical procedure that filters blood when the kidneys are not functioning properly) communication for one of two residents reviewed for dialysis (Resident R8).Findings include: Review of facility policy entitled Hemodialysis dated 2/2/26, indicated Ongoing communication and collaboration with the dialysis facility regarding dialysis care and services. The facility will communicate with the dialysis facility.any significant weight changes, nutritional concerns, medication administration or withholding of certain medications prior to the dialysis treatment and document. and As appropriate, the administrator, nursing director. should review the facility's dialysis care and services on an ongoing basis including: Communication and coordination between the facility and the dialysis facility. Review of Resident R8's clinical record revealed an admission date of 11/16/20, with diagnoses that include dependence of renal dialysis (a treatment that helps remove extra fluid and waste products from the blood when the kidneys are not able to), Diabetes (a health condition that is caused by the body's inability to produce enough insulin), and gastro-esophageal reflux disease (a condition when stomach acid repeatedly flows back up into your throat). Review of Resident R8's physician orders revealed an order dated 11/25/25, for Hemodialysis every Tuesday, Thursday, and Saturday. Review of Resident R8's dialysis communication forms lacked evidence that communication forms were completed and/or sent for every dialysis treatment. During an interview on 4/15/26, at approximately 1:00 p.m. Resident R8 revealed that his/her dialysis communication form is not always sent with him/her to his/her dialysis treatments. During an interview on 4/15/26, at 1:52 p.m. the Director of Nursing (DON) confirmed that there was no evidence of dialysis communication forms being completed for every dialysis treatment for Resident R8. The DON also confirmed that a dialysis communication form should be completed and sent with Resident R8 for every dialysis treatment. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18 (b)(1) Management 28 Pa. Code 201.18 (e)(1) Management

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395041	A. Building B. Wing	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Twinbrook Healthcare and Rehabilitation Center	3805 Field Street Erie, PA 16511

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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 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. Based on review of facility policy and clinical records, and staff interviews, it was determined that the facility failed to ensure that the physician signed and dated all orders during visits for one of 28 residents reviewed (Resident R94). Findings include: Review of facility policy entitled Attending Physician Documentation Responsibility dated 2/2/26, indicated The attending physician will visit residents in a timely fashion, consistent with applicable state and federal requirements. Review of facility policy entitled Physician Services date 2/2/26, indicated Physician orders and progress notes shall be maintained in accordance with current OBRA [Omnibus Budget Reconciliation Act] regulations and facility policy. Resident R94's clinical record revealed an admission date of 2/17/26, with diagnoses that included gastrointestinal hemorrhage (excessive bleeding in the digestive tract), hypertension, and transient ischemic attack and cerebral infraction (also known as a stroke it occurs when blood flow to part of the brain is blocked). Review of Resident R94's clinical record lacked evidence of the last time his/her physician reviewed, signed, and dated his/her physician orders. During an interview on 4/15/26, at 12:30 p.m. the Director of Nursing (DON) confirmed that physician orders for Resident R94 lacked evidence that they were reviewed and signed by the physician. The DON also confirmed that physician orders should be reviewed and signed with every physician visit on admission then every 30 days for the first 90 days then every 60 days. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1)(3) Management 28 Pa. Code 211.5(f)(i) Medical records

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. Based on review of clinical records, resident interviews and staff interviews, it was determined that the facility failed to ensure that physician visits were conducted at least once every 30 days for the first 90 days after admission and at least 60 days thereafter for one of 28 residents reviewed (Resident R94). Findings include: Review of facility policy entitled Attending Physician Documentation Responsibility dated 2/2/26, indicated The attending physician will visit residents in a timely fashion, consistent with applicable state and federal requirements. and The visit schedule will be at least every 30 days for the first 90 days after admission and then at least every 60 days thereafter. Review of facility policy entitled Physician Services date 2/2/26, indicated Physician orders and progress notes shall be maintained in accordance with current OBRA [Omnibus Budget Reconciliation Act] regulations and facility policy. Resident R94's clinical record revealed an admission date of 2/17/26, with diagnoses that included gastrointestinal hemorrhage (excessive bleeding in the digestive tract), hypertension, and transient ischemic attack and cerebral infraction (also known as a stroke it occurs when blood flow to part of the brain is blocked). Review of Resident R94's clinical record lacked evidence that he/she was seen by his/her physician every 30 days for the first 90 days after admission as required. During an interview on 4/12/26, at approximately 11:30 a.m. Resident R94 expressed that he/she has not seen his/her physician. During an interview on 4/15/26, at 12:30 p.m. the Director of Nursing (DON) confirmed that the clinical record lacked evidence that Resident R94 was seen by their physician as required and also confirmed that all residents should be seen by their physician every 30 days for the first 90 days then every 60 days thereafter. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1)(3) Management 28 Pa. Code 211.5(f)(ii)(vii) Medical records

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on review of facility policy, clinical records, observations, and staff interviews, it was determined that the facility failed to follow acceptable infection control practices regarding enhanced barrier precautions (EBP) during observation of a resident with a foley catheter (tubing inserted into the bladder to drain urine) (Resident R7), and failed to prevent the potential for cross-contamination (transfer of germs from one location to another) for one resident receiving nebulizer treatments (a treatment that delivers medication directly to the lungs to treat respiratory conditions) (Resident R15).Findings include: Review of facility policy entitled Enhanced Barrier Precautions Policy dated 2/2/26, indicated To prevent transmission of Multidrug Resistant Organisms (MDRO's){a germ resistant to many antibiotics} by enhancing personal protective equipment(PPE) use beyond standard precautions during high-contact resident care; gowns and gloves must be worn during device care(central lines, urinary catheters, feeding tubes, tracheostomies);clear signage must be placed at the room entry indicating EBP requirement; gowns and gloves must be immediately accessible. Center for Disease Control and Prevention (CDC) defines Enhanced Barrier Precautions as an infection control intervention designed to reduce transmission of MDRO's using an approach of isolation gown and gloves during high-contact resident care activities including catheter care. CDC further indicates that facilities should post clear signage indicating EBP requirements, and ensure easy access to gowns, gloves, and alcohol-based hand rub. Review of facility policy entitled Nebulizer Use, Cleaning, and Maintenance dated 2/2/26, indicated To provide safe, effective respiratory medication delivery while preventing cross-contamination. and Storage. store the kit in a clean, breathable, labeled bag. inside the residents bedside drawer. Resident R7's clinical record revealed an admission date of 8/16/22, with diagnoses that included Chronic Kidney Disease (a long-term condition in which the kidneys are damaged and gradually lose their ability to function properly over time, gastro-esophageal reflux disease (GERD - a condition where stomach acid flows back into the esophagus [tube that passes food from the mouth into the stomach]), and high blood pressure. Review of Resident R7's clinical record on 4/13/26, revealed a physician's order dated 4/9/26, for an Indwelling catheter. Resident R7's physician order failed to include an order for Enhanced Barrier Precautions Observations on 4/13/26, at 1:00 p.m. and 2:13 p.m., revealed Resident R7 sitting in a wheelchair in his/her room with an indwelling catheter positioned below the bladder. Observation of Resident R7's room revealed that there was no signage alerting persons entering the room of EBP for infection control and no personal protective equipment (PPE) such as gloves and gowns available inside or outside of the room for use. During an interview on 4/14/26, at 2:15 p.m. the Licensed Practical Nurse Employee E4 confirmed that Resident R7's room lacked signage of EBP and appropriate PPE, such as gloves and gowns, when providing care for residents who have an Indwelling urinary catheter, and that signage should have been posted and PPE should be readily available. Review of Resident R15's clinical record revealed an admission date of 7/7/22, with diagnoses that included chronic obstructive pulmonary disease (when your lungs do not have adequate air flow), gastro esophageal reflux disease (a condition when stomach acid repeatedly flows back into your throat), and chronic respiratory failure (a condition where your lungs don't exchange air properly). Review of Resident R15's physician orders revealed an order for albuterol sulfate nebulization solution (a liquid medication) 2.5mg (milligrams) 3ml (milliliters) inhale via nebulizer two times a day dated 8/4/25. Observations on 4/13/26, at 1:04 p.m. and again at 2:37 p.m. revealed a nebulizer machine (a medical device that turns liquid medication into a fine mist) sitting on the bedside stand next to resident R15's bed with a mask (a device that is connected to a nebulizer machine allowing a person to inhale medication directly into their lungs) lying on the floor. During an interview on 4/13/26 at 2:40 p.m. Registered Nurse Employee E3 confirmed that the nebulizer mask was lying on the floor. He/she also confirmed that the mask should not be on the floor and should be stored in a bag in Resident R15's drawer. 28 Pa. Code 211.10(c) Resident care policies 28 Pa. Code 211.12(d)(1)(5) Nursing services