STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396114	A. Building B. Wing	06/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Twin Pines Health Care Center	315 East London Grove Road West Grove, PA 19390

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 Level of Harm - Actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the facility's policy, clinical records, hospital records, and interviews with staff, nurse practitioner, resident, and family, it was determined the facility failed to timely notify and report accurate information of a resident's change in condition to the physician for one of two residents reviewed (Resident 1). This failure resulted in actual harm of the resident when they were hospitalized , requiring intubation, mechanical ventilation, and ICU (Intensive Care Unit) admission for monitoring. Findings Include: Review of the facility's policy titled Resident Change in Condition Policy, last reviewed on June 2, 2025, revealed The licensed nurse will recognize and intervene in the event of a change in resident condition. The Physician/Provider and the family/Responsible Party will be notified as soon as the nurse has identified the change in condition. Review of Resident 1's diagnosis list includes Multiple Sclerosis (condition that causes breakdown of the protective covering of nerves; causing numbness, weakness, trouble walking, vision changes, and other symptoms) Neurogenic bladder (occurs when nerve damage disrupts the communication between your brain, spinal cord, and bladder muscle), and UTI (Urinary Tract Infection). Review of Resident 1's Quarterly Minimum Data Set (MDS- periodic assessment of resident needs) assessment dated [DATE] revealed the resident had a Basic Interview for Cognitive Status score of 15 indicating the resident had no cognitive impairment. Review of Resident 1's active care plan revealed Resident had an altered elimination r/t (related to) suprapubic catheter (flexible tube inserted through the lower abdomen directly into the bladder to drain urine). The interventions include assessing/recording signs of UTI (pain, burning, blood-tinged urine, cloudiness, change in behavior), catheter output every shift, recording output amount every shift, and as needed. Interview was conducted with Resident 1 on June 22, 2026, at 11:00 a.m. The resident, who was alert and oriented, revealed they had a catheter for a while now and had previous episodes of UTI. The Resident reported starting to have pain in their private area on Saturday (May 23, 2026) and reported to their nurse. The resident revealed they knew they were experiencing a UTI. Resident 1 further revealed feeling so sick they could not remember what happened for the next few days. Review of Resident 1's nursing progress notes from a Licensed Practical nurse Employee E4 dated May 24, 2026, (10:33 a.m.), revealed Resident c/o (complained of) difficulty urinating/pain at cath (catheter) site, states has a UTI. [resident] Thinks hasn't had a BM (bowel movement), and that's what may be blocking [resident]'s urine. Nsg sup (nursing supervisor) made aware and handling concerns. Review of Resident 1's clinical record failed to reveal documentation indicating Resident 1's physician was notified of the resident's complaint of pain at the catheter site on the morning of May 24, 2026. Review of Resident 1's progress notes failed to reveal documentation of the resident expressing pain in their private area. Phone interview conducted with Resident 1's wife on June 22, 2026, (11:30 a.m.) revealed spouse called Resident 1 on May 24, 2026 (Sunday) by phone but was informed Resident 1 could not talk because resident was tired, not feeling well, and just wanted to sleep. Call from the nurse practitioner was received on May 25, 2026, around 9:00 a.m., and informed spouse of the resident not feeling well, but vitals were normal, orders (lab studies, etc) were initiated. The spouse revealed it didn't feel right, so she decided to come to (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 0580 Level of Harm - Actual harm Residents Affected - Few	the facility to visit the resident. She got another call from the NP (Nurse Practitioner) while on the way to the facility and told them she was five minutes away. The wife reported that upon arrival, she observed the resident lying in bed, gurgling in the mouth, and not responding to her. She pressed the call bell and heard licensed nurse Employee E3 approaching and said, I don't know who pressed the call bell, probably [they] recovered. The wife informed Employee E3 that she pressed the call bell and demanded Resident 1 be sent to the hospital immediately. 911 was called, and the resident was sent to the hospital. Interview with Registered Nursing Employee E3 conducted on June 22, 2026, at 12:00 p.m., revealed Employee E3 was not notified of Resident 1's change in condition the morning of May 25, 2026. Employee E3 reported assessing the resident and observed the resident with a decline, change in mental status, and not talking to me. Employee E3 confirmed he/she did not check the resident's vitals, and the information reported to the NP was from Licensed Practical Nursing Employee E4. Interview with Licensed Practical Nurse, Employee E4 conducted on June 22, 2026, at 12:30 p.m. revealed Employee E4 reported the LPN (Licensed Practical Nurse) informs the Supervisor/RN's (Registered Nurses) of a resident's change in condition, and they are the ones who call the physician. Employee E4 confirmed reporting Resident 1's change in condition to Registered Nurse Employee E3 on May 24, 2026. Continued interview with Licensed Practical Nurse (LPN) Employee E4 conducted on June 22, 2026, approximately 12:30 p.m., revealed the resident's vitals provided to Registered Nursing Employee E3 were the same vitals they documented on the nursing progress notes on May 25, 2026. Employee E4 further revealed I cringed when I read [Employee E3] notes indicating the resident's vitals were within normal limits because it wasn't. The Blood pressure of 154/90 and heart rate of 111 were abnormal. Phone interview with Nurse Practitioner (NP) Employee E5 was conducted on June 22, 2026, at 12:45 p.m. The NP confirmed their office did not receive a call from the facility the morning of May 24, 2026, regarding resident 1's complaint of pain at the catheter site. When asked what they would have done if they were notified, the NP responded, I would have ordered to start IV (Intravenous - administered through veins) fluids and an antibiotic, [resident] gets septic quickly. Continued phone interview conducted with Nurse Practitioner (NP), Employee E5, June 22, 2026, revealed as per documentation from the on-call NP on May 25, 2026, a call was received from the facility at 8:44 a.m., indicating Resident 1 was lethargic resulting in an order for IV fluids, antibiotic (Cipro), and lab work. The NP further revealed another call was received from the facility at 10:49 a.m., reporting the resident opens eyes but was not themselves. The vitals reported to the NP by the nurse were HR- 76, B/P 128/74, R- 16, T-98.1, and Spo2 96%, which were all within normal range. The NP revealed a 3-way call with the facility and the wife was made to give an update on the resident's condition. At 1:30 p.m. on May 25, 2026, the office received another call from the facility indicating Resident 1 was sent to the hospital at 12:30 p.m., as requested by the wife. The NP revealed that based on the on-call NP's documentation on May 25, 2026, the on-call NP was not informed that the resident was clammy, pale, drooling, non-verbal, and with a HR of 111 as documented by Employee E4 on the morning of May 25, 2026. The NP further revealed they would have sent Resident 1 to the hospital immediately if they were provided with an accurate assessment. The NP further stated, Assessment (of the resident) was presented differently to us. Review of Resident 1's clinical record failed to reveal documentation indicating Resident 1's vital signs or urine output were monitored May 24, 2026, on the 3-11 (p.m.) and 11 p.m.-7 a.m. shifts. Review of Resident 1's nursing progress notes dated May 25, 2026 (6:28 a.m.), revealed: continue to c/o discomfort, pt (patient) in a stable condition, verbalize I think I have UTI, MD (physician) to be made aware. Review of Resident 1's nursing progress notes authored by Licensed Practical Nurse, Employee E4 dated May 25, 2026, (10:48 a.m.), revealed Resident was lethargic, drooling thick mucus, clearish [clear] pale yellow in color. Attempted to wake the resident up and open their eyes and touch their shoulder. [Resident] was not able to verbalize anything. The resident was clammy and pale in color. The resident has MS and has weakness, but the weakness on the L (left) side appears to be more than usual. No medications administered. Nsg. Sup, made aware and assessed. Nsg. Sup. to follow as Nsg. (continued on next page)

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F 0580 Level of Harm - Actual harm Residents Affected - Few	Sup had received orders from [physician company]. Continued review of same progress note revealed, CNA (Certified Nursing Assistant) reported resident's condition to the nurse at 8:30 a.m. Vitals: HR (heart rate) 111 (normal range 60-100 bpm), R (respirations)- 16, 95% Spo2 in room air, B/P (blood pressure)- 154/90, T (temperature) - 97.8. Review of Resident 1's nursing progress notes authored by Registered Nursing Employee E3 dated May 25, 2026, (12:18 p.m.), revealed Assessed resident this a.m., and found to be arousable but not responsive. [Resident] vital signs were wnl (within normal limit) and were afebrile (no fever). Abdomen distended and hard, tried to irrigate the Foley, but it was blocked, so a new suprapubic catheter was inserted, returning 1000 of blood-tinged urine. The resident did become more comfortable, but still not responsive. [Provider's company] called and ordered an IV, but a site could not be found. [Provider's company] contacted again and stated wife is in transition to the facility, and she will make a determination for future orders. Wife arrived and stated that she wanted resident sent to [hospital], wife followed. Review of Resident 1's hospital records including Discharge Summary dated May 31, 2026, revealed resident was admitted to the hospital on [DATE], with diagnosis of Acute Respiratory Failure with Hypoxia (condition when lungs fail to adequately oxygenate the blood and remove carbon dioxide), Septic shock (severe and dangerous stage of sepsis, occurring when an infection triggers a systemic immune overreaction), Acute Kidney Injury and UTI. Further review of the same report revealed On arrival, [patient] was found to be profoundly hypoxic (state of inadequate oxygen reaching the body's tissues and cells to support normal functions) and Encephalopathic (condition that causes brain dysfunctions), requiring intubation and mechanical ventilation. [Patient] was managed in the ICU with full ventilatory support. Interview with the Director of Nursing (DON) conducted on June 22, 2026, at 1:30 p.m. The DON denied that only the RN/supervisor can call the physician for a resident's change in condition. The above findings were conveyed to the DON and NHA (Nursing Home Administrator) on June 22, 2026, at 1:45 p.m. The facility failed to ensure Resident 1's change in condition was timely and accurately communicated with the physician resulting in actual harm when Resident 1 was admitted to the hospital to ICU on a ventilator with a diagnosis of septic shock and UTI. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing service 28 Pa Code 211.5(f) Clinical Records 28 PA Code 211.10(a) Resident care policies

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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 a clinical records review, interview with staff and Nurse Practitioner (NP), it was determined that the facility failed to practice professional standards of nursing by performing a procedure without a physician's order for one of two residents reviewed (Resident 1). Findings: A review of Resident 1's diagnosis list includes Multiple Sclerosis (a disease that causes breakdown of the protective covering of nerves, causing numbness, weakness, trouble walking, vision changes, and other symptoms), Neurogenic bladder (Occurs when nerve damage disrupts the communication between your brain, spinal cord, and bladder muscle), and UTI (Urinary Tract Infection). A review of Resident 1's active care plan revealed Resident had an altered elimination r/t (related to) suprapubic catheter (A flexible tube inserted through the lower abdomen directly into the bladder to drain urine). A review of Resident 1's nursing progress notes dated May 24, 2026, at 10:33 a.m., revealed Resident c/o (complained of) difficulty urinating/pain at Cath (catheter) site, states [resident] has a UTI. Thinks [resident] hasn't had a BM (bowel movement), and that's what may be blocking [resident]'s urine. Nsg sup (nursing supervisor) made aware and handling concerns. A review of Resident 1's nursing progress notes dated May 25, 2026, at 12:18 p.m., revealed Assessed resident this a.m., and found to be arousable but not responsive. [Resident] vital signs were wnl (within normal limits) and were afebrile (no fever). Abdomen distended and hard, tried irrigating the Foley, but it was blocked, so a new suprapubic catheter was inserted, returning 1000 of blood-tinged urine. A review of Resident 1's physician order revealed that there was no order to replace Resident 1's suprapubic catheter. A phone interview with the NP, Employee E5, conducted on June 22, 2026, at 12:45 p.m., confirmed that there was no order to replace Resident 1's suprapubic catheter on May 25, 2026. An interview with the DON on June 22, 2026, at 12:45 p.m., confirmed that there were no written orders to change Resident 1's suprapubic catheter on May 25, 2026. The facility failed to practice professional standards of nursing by changing Resident 1's suprapubic catheter without a physician's order. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing service

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on clinical records review and staff interviews, it was determined that the facility failed to provide consistent monitoring of the resident's urine output and perform a procedure with a physician's order for one of the two residents reviewed (Resident 1). Findings: A review of Resident 1's diagnosis list includes Multiple Sclerosis (a disease that causes breakdown of the protective covering of nerves, causing numbness, weakness, trouble walking, vision changes, and other symptoms), Neurogenic bladder (Occurs when nerve damage disrupts the communication between your brain, spinal cord, and bladder muscle), and UTI (Urinary Tract Infection). A review of Resident 1's active care plan revealed Resident had an altered elimination r/t (related to) suprapubic catheter (A flexible tube inserted through the lower abdomen directly into the bladder to drain urine). The interventions include assessing/recording signs of UTI (pain, burning, blood-tinged urine, cloudiness, change in behavior), Catheter output every shift, recording output amount every shift, and as needed. A review of Resident 1's nursing progress notes dated May 24, 2026, at 10:33 a.m., revealed Resident c/o (complained of) difficulty urinating/pain at Cath (catheter) site, states [resident] has a UTI. Thinks [resident] hasn't had a BM (bowel movement), and that's what may be blocking [resident]'s urine. Nsg sup (nursing supervisor) made aware and handling concerns. A review of Urine output monitoring records provided by the Director of Nursing (DON) revealed that residents had 450 ml of urine on May 24, 2026, at 1:20 p.m. There was no urine output documented on May 24, 2026, at the 3-11 and 11-7 shift. A review of Resident 1's nursing progress notes dated May 25, 2026, at 12:18 p.m., revealed Assessed resident this a.m., and found to be arousable but not responsive. [Resident] vital signs were wnl (within normal limits) and were afebrile (no fever). Abdomen distended and hard, tried irrigating foley but it was blocked, so a new suprapubic catheter was inserted, returning 1000 of blood-tinged urine. A review of Resident 1's physician order revealed that there was no order to replace Resident 1's suprapubic catheter on May 25, 2026. An interview with the DON on June 22, 2026, at 12:45 p.m., confirmed that there were no written orders to change Resident 1's suprapubic catheter on May 25, 2026. The facility failed to ensure Resident 1's urine output was monitored, and a procedure to replace the resident's suprapubic catheter was done with a physician's order. 28 Pa. Code 211.12(d)(1)(3)(5) Nursing service 28 Pa Code 211.5(f) Clinical Records