

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396114	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/05/2024
NAME OF PROVIDER OR SUPPLIER Twin Pines Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>37789</p> <p>Based on observation, it was determined that the facility failed to provide privacy and confidentiality of residents ' personal information on two of four nursing units (South and East).</p> <p>Findings include:</p> <p>Observation on the East unit on April 2, 2024, at approximately 10:00 a.m. revealed the computer on the medication cart was left unattended with Resident 85's physician orders displayed. Several residents and other staff were noted nearby the medication cart.</p> <p>Observation on the South unit on April 3, 2024, at approximately 8:00 a.m. revealed the computer on the medication cart was left unattended with Resident 59's physician orders displayed. Several residents and other staff were noted nearby the medication cart.</p> <p>Observation on the East unit on April 5, 2024, at approximately 8:30 a.m. revealed the computer on the medication cart was left unattended with Resident 29's physician orders displayed. Several residents and other staff were noted nearby the medication cart.</p> <p>Interview with the Director of Nursing on April 5, 2024, at 10:20 a.m. confirmed the above findings.</p> <p>28 Pa. Code: 201.18 (e)(1) Management</p> <p>28 Pa. Code: 201.29 (j) Resident rights</p> <p>28 Pa. Code: 211.5 (f) Clinical records</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 0661</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46166</p> <p>Based upon clinical record review, it was determined the facility failed to complete discharge summary on the day of planned discharge for one of three residents reviewed (Resident 109).</p> <p>Findings include:</p> <p>Review of Resident 109's clinical record revealed Resident 109 was admitted to the facility on [DATE], and was discharged to home on March 23, 2024.</p> <p>Review of Resident 109's clinical record failed to reveal a discharge summary completed on March 23, 2024, the day of a planned discharge.</p> <p>The above information was conveyed to the Nursing Home Administrator on April 5, 2024, at 11:00 a.m.</p> <p>28 Pa. Code 211.5(f) Clinical Records</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>46166</p> <p>Based on a comprehensive review of clinical records, observations, and interviews with residents and staff, it was determined that the facility failed to consistently implement and maintain infection control practices, thereby risking the potential spread of infection for one resident requiring contact precautions (a method to prevent the transmission of infectious agents spread by direct or indirect contact with the patient or the patient's environment) out of 32 residents sampled (Resident 90).</p> <p>Findings include:</p> <p>Review of the facility's policy Transmission-Based Precautions and Isolation Policy with a revision date of March 3, 2024, states that Contact precautions also apply where the presence of excessive wound drainage, urine, or fecal incontinence, or other discharges from the body suggest an increased potential for environmental contamination and risk of transmission. Personal Protective Equipment (PPE) recommended includes gloves and gowns.</p> <p>Review of the CONTACT PRECAUTIONS sign reveals instructions for all personnel to clean their hands before entering and leaving the room, and for providers and staff to don gloves and gowns before room entry and discard them before room exit.</p> <p>A review of Resident 90's clinical medical record revealed a progress note dated March 28, 2024 at 1:01 p. m. stating Resident 90's urinary analysis (UA) came back positive for Extended Spectrum Beta-Lactamase e-coli (ESBL, are enzymes produced by certain bacteria, including Escherichia coli that make bacteria resistant to certain antibiotic medicines) (Escherichia-coli, is a group of bacteria that can cause infections in one's gut, urinary tract and other parts of your body).</p> <p>During a tour of nursing unit East on April 2, 2024, at 10:31 a.m., it was observed that the PPE station, including gloves, gowns, and face shields, was available, but the contact precaution sign was placed face down on top of the container outside Resident 90's room.</p> <p>Additional observations conducted on nursing unit East on April 2, 2024, at 10:33 a.m. revealed three nursing staff performing incontinence care (helping an individual with any type of urinary or bowel leakage to maintain their health, and wellbeing) on Resident 90 with only gloves on.</p> <p>Observations conducted on April 3, 2024, at 9:36 a.m., witnessed a nursing staff exiting Resident 90's room holding soiled bed linens without wearing a gown.</p> <p>Additional observations of Resident 90's room on April 3, 2024, at 9:39 a.m. observed two nursing staff entering Resident 90's room without washing their hands or donning PPE. At 9:35 a.m. licensed practical nurse (LPN) licensed employee (E4) exited Resident 90's room without washing her hands.</p> <p>Interview conducted with licensed employee E4 on April 3, 2024, at 9:35 a.m. revealed E4 was unaware resident 90 was on contact precautions or that Resident 90's UA returned positive for ESBL E-coli.</p> <p>(continued on next page)</p>		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<p>Interview conducted with Infection Preventionist (IP) licensed employee (E3) on April 3, 2024, at 1:18 p.m. confirmed Resident 90 is on contact precaution and that all staff need adhere to the facility's transmission-based precautions and isolation policy.</p> <p>The above information was confirmed by licensed employee E3 on April 3, 2024, at 1:24 p.m.</p> <p>28 Pa. Code 211.10 (a)(d) Resident care policies</p> <p>28 Pa. Code 211.12 (c)(d)(1)(2)(5) Nursing Services.</p>		