

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 03/07/2025
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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>35913</p> <p>Based upon clinical record review and interview, it was determined the facility failed to ensure residents' physician was notified regarding a resident and failed to ensure residents' physician was notified of a significant weight loss for two of two residents reviewed (Resident 72 and Resident 104).</p> <p>Findings include:</p> <p>Review of Resident 72's clinical progress notes dated July 27, 2024, at approximately 5:45 a.m. revealed Resident 72 suffered a fall out of bed and was found laying on the floor on resident's right side.</p> <p>Further review of Resident 72's clinical progress notes revealed Resident 72 complained of pain upon leg movement. After assessment by facility staff, Resident 72 was returned to bed.</p> <p>Review of clinical documentation failed to reveal evidence that Resident 72's physician or nurse practitioner were notified of the fall that occurred at 5:45 a.m.</p> <p>Further review of Resident 72's progress notes dated July 27, 2024, at 7:20 a.m. revealed Resident 72 was unable to bear weight and continued to complain of pain in the left lower extremity. Resident 72's nurse practitioner was then notified of the fall that had occurred at 5:45 a.m. and an x-ray was ordered at that time.</p> <p>Review of Resident 72's x-ray report dated July 27, 2024, revealed Resident 72 sustained a fracture of the left femoral (large bone in leg) neck and was subsequently transferred to an acute care facility.</p> <p>Interview with the Director of Nursing on March 7, 2025, at 10:00 a.m. confirmed Resident 72's physician was not notified at the time of Resident 72's fall with injury.</p> <p>28 Pa. Code 211.12(d)(1)(2)(3) Nursing Services</p> <p>Previously cited 4/5/2024</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 0636</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.</p> <p>47968</p> <p>Based on clinical record reviews, interviews with staff and residents, it was determined that the facility failed to conduct an accurate comprehensive assessment for one of 32 residents reviewed. (Resident 51)</p> <p>Findings include:</p> <p>Clinical record review revealed a quarterly assessment MDS (a minimum data set, which was part of the U. S. federally mandated process for clinical assessment of all residents in Medicare or Medicaid-certified nursing homes) dated January 1, 2025, that indicated Resident 51 obtained a stage 2 pressure ulcer (a shallow, open sore or an intact or ruptured blister, with a red or pink wound bed caused by prolonged exposure to pressure) while residing in the facility.</p> <p>Further review of Resident 51's MDS revealed a Brief Interview for Mental Status (BIMS) score of 15.</p> <p>Review of Resident 51's clinical records revealed wound care notes dated February 18, 2025, documenting the resident had a skin tear (a traumatic wound that occurs when the top layer of skin separates from the deeper layers) on his/her inner thigh that was being treated with Medihoney (a typical first aid and wound care product) and dressing.</p> <p>Review of Resident 51's clinical records revealed wound care notes dated February 25, 2025, documenting the resident had a skin tear on inner thigh with treatment changed to skin prep.</p> <p>Further review of Resident 51's clinical records revealed wound care notes dated March 4, 2025, documenting the resident had a skin tear on inner thigh that was improving.</p> <p>Review of Resident 51's clinical records revealed that the resident did not have orders for treatment of a stage 2 pressure ulcer.</p> <p>Review of Resident 51's clinical records revealed a care plan last revised on November 15, 2024, documenting the resident is at risk for skin injury related to immobility, paraplegia (paralysis to lower half of body), a history of stage 4 wounds, and a history of tendon release surgery (procedure used to treat muscular skeleton conditions).</p> <p>Interview of Resident 51 on March 5, 2025, at 9:37 am revealed they currently did not have a pressure ulcer. Resident 51 was unable to state the last time he/she had a pressure ulcer.</p> <p>Interview with Register Nurse Employee E4 on March 6, 2025, at 11:58 AM revealed the resident did not have a stage 2 pressure ulcer at the time of the MDS assessment and the resident only had a skin tear.</p> <p>(continued on next page)</p>

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<p>F 0636</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with the MDS Coordinator, Employee E5 on March 6, 2025, at 2:05 p.m., confirmed a data entry error was made on Resident 51's MDS and the resident did not have a facility acquired pressure ulcer at the time of its completion on January 1, 2025.</p> <p>28 Pa Code 211.12 (d)(1) Nursing services</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46166</p> <p>Based on observations, clinical record review, and staff interview, it was determined that the facility failed to develop a comprehensive care plan for one of two residents reviewed regarding oxygen use. (Resident R6)</p> <p>Findings include:</p> <p>Resident R6's clinical record revealed that the resident was admitted to the facility on [DATE], with diagnoses of acute on chronic systolic heart failure (long-term condition that happens when your heart can't pump blood well enough to give your body a normal supply), chronic obstructive pulmonary disease, unspecified (a progressive lung disease that makes it difficult to breathe due to obstruction of airflow).</p> <p>Review of Resident R6's Minimum Data Set (MDS - a periodic assessment of care needs) upon admission, revealed a Brief Interview for Mental Status (BIMS) of 15 which indicated that the resident was cognitively intact.</p> <p>On March 4, 2025, Resident R6 was observed in their room using supplementary oxygen.</p> <p>Review of Resident R6's clinical records revealed the following order administer oxygen via nasal cannula continuously at 2 liters/minute.</p> <p>A review of the current care plan, dated January 21, 2025, found no evidence of a comprehensive, person-centered plan of care addressing oxygen interventions.</p> <p>During an interview on March 7, 2025, at 11:23 a.m., the Director of Nursing (DON), confirmed that Resident R6 had an active order for continuous oxygen and acknowledged that no comprehensive care plan had been developed to address oxygen interventions.</p> <p>28 Pa. Code 201.14 (a) Responsibility of Licensee</p> <p>28 Pa. Code 201.18 (b)(1)(3) Management</p> <p>28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35913</p> <p>Based upon clinical record review and interview, it was determined the facility failed to ensure a fluid restriction, ordered by resident's physician, was monitored for one of one resident reviewed (Resident 99).</p> <p>Findings include:</p> <p>Review of Resident 99's diagnosis list revealed diagnoses including congestive heart failure (CHF - excessive body/lung fluid caused by a weakened heart muscle) and dementia (irreversible, progressive degenerative disease of the brain, resulting in loss of reality contact and functioning ability).</p> <p>Review of Resident 99's clinical record revealed the resident was admitted to the facility on [DATE] with an order for a 2-liter (2L) a day fluid restriction.</p> <p>Review of Resident 99's clinical record failed to reveal evidence that nursing was monitoring Resident 99's daily 2L fluid restriction.</p> <p>Interview with the Director of Nursing on March 7, 2025, at 9:35 a.m. confirmed that nursing was not monitoring Resident 99's 2L fluid restriction as ordered by the physician. This interview further revealed that, per the Director of Nursing, upon review Resident 99 should not have been on a fluid restriction from admission and the fluid restriction was removed on March 7, 2025.</p> <p>28 Pa. Code 211.12(d)(1)(2)(3) Nursing Services</p> <p>Previously cited 4/5/2024</p>

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>35913</p> <p>Based upon clinical record review and interview, it was determined the facility failed to ensure adequate monitoring of a resident with a significant weight loss (Resident 104).</p> <p>Findings include:</p> <p>Review of Resident 104's diagnosis list revealed diagnoses including protein-calorie malnutrition and adult failure to thrive.</p> <p>Review of Resident 104's weight summary revealed the resident weighed 136.6 pounds on December 8, 2024, and weighed 128.4 pounds on December 22, 2024, indicating a 6 percent weight loss in 14 days.</p> <p>Review of Resident 104's clinical record failed to reveal evidence that Resident 104's physician was not notified of Resident 104's significant weight loss.</p> <p>Review of clinical documentation revealed no re-weight was obtained to ensure accuracy of the weight loss.</p> <p>Interview with Licensed Employee E3 on March 7, 2025, at 9:38 a.m. revealed a re-weight should have been obtained to ensure accuracy of the weight loss.</p> <p>Further interview with Licensed Employee E3 on March 7, 2025 confirmed that Resident 104's physician was not notified of the weight loss and the loss was not address.</p> <p>28 Pa. Code 211.12(d)(1)(2)(3) Nursing services</p> <p>Previously cited 4/5/2024</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>51168</p> <p>Based upon observations, clinical record review and staff interviews, it was determined that the facility failed to ensure fluid restrictions were followed for one of one dialysis resident reviewed. (Resident 16).</p> <p>Findings include:</p> <p>Review of Resident 16's clinical record revealed diagnoses including but not limited to end stage renal disease (ESRD- failure of kidney function to remove toxins from blood) and dementia (general loss of cognitive abilities, including memory).</p> <p>Review of Resident physician's orders revealed an order for daily fluid restriction of 1500 ml daily as follows: Nursing to give 7-3 shift 240 ml; 3-11 shift 660 ml; 11-7 shift 120 ml; dietary daily 480 ml.</p> <p>Review of Resident 16's Fluid Task sheet revealed Resident 16 exceeded the daily fluid restriction allotment as follows: February 11, 2025 - 420 ml; February 14, 2025- 420 ml; February 15, 2025- 540 ml; February 17, 2025 - 300 ml; March 1, 2025 - 780 ml; March 2, 2025 - 420 ml; March 5, 2025-180ml; March 6, 2025-300ml.</p> <p>Interview with Director of Nursing on March 7, 2025, at approximately 12:25pm confirmed the above findings.</p> <p>28 Pa. Code: 211.5(f) Clinical records</p> <p>28 Pa. Code 211.12(d)(1)(5) Nursing Services</p>		