

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 04/30/2026
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)		
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and staff interview, it was determined that the facility failed to ensure that food stored in the walk-in fridge and freezer were properly stored to prevent contamination and ensure safe storage in accordance with professional standards for food service safety in the main kitchen. Findings include: Observations in the walk-in freezer in the kitchen on April 27, 2026, at 9:30 a.m., in the presence of the Dietary Manager Employee E5 revealed the following: one bag of frozen biscuits inside an open plastic bag placed within an open cardboard box, frozen diced carrots inside an opened plastic bag placed within an open cardboard box. Observations on April 28, 2026, at 1:30 p.m., in the presence of Employee E5 revealed the following: frozen spinach inside an opened plastic bag placed within a cardboard box and frozen hamburger patties inside an opened plastic bag placed within a cardboard box. Interview with Employee E5 on April 30, 2026, at 1:00 p.m., confirmed that the above-mentioned foods observed on April 27, 2026, and April 28, 2026, were not properly stored. The above findings were conveyed with the Nursing Home Administrator (NHA) on April 30, 2026, at 1:40 p.m. The facility failed to ensure that food stored in the walk-in freezer in the main kitchen was properly stored to prevent contamination and ensure safe storage in accordance with professional standards for food service safety. 28 Pa. Code 211.6(f) Dietary 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
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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>Based on observations, clinical records review and staff interviews, it was determined that the facility failed to ensure care plans were updated for appropriate wheelchair positioning for one of eight residents reviewed (Resident 9). Findings revealed: A review of Resident 9's quarterly Minimum Data Set (MDS- A standardized assessment tool that measures health status in long-term care residents) dated August 7, 2025, revealed resident had a diagnosis of Alzheimer's' Disease (irreversible, progressive degenerative disease of the brain, resulting in loss of reality contact and functioning ability), Seizure disorders (A chronic neurological condition characterized by recurrent seizures caused by abnormal electrical activity in the brain), and Contracture-knee (A permanent, stiffening of muscles, tendons, ligaments or skin, causing restriction in joint movement). The same MDS revealed that residents' cognition was severely impaired and dependent on all ADL's (activities of daily living). A review of Resident 9's progress notes dated September 17, 2025, at 11:01 a.m., revealed Resident observe laying on the floor in the common living room area. Resident was laying prone in front of (their) wheelchair when staff observed (them). Resident was assessed for injury, noted with hematoma (Localized collection of clotted blood outside blood vessel) to R (right) frontal area of forehead, abrasion noted on the area with minimal bleeding, pressure dressing applied. An observation conducted on April 29, 2026, at 9:45 a.m., revealed Resident 9 was lying in bed with eyes closed, both legs and arms were flexed. Further observations revealed licensed Employee E6 approached and spoke to the resident, raised the head of the bed and administered the resident's medications. The resident did not move during the entire observation. A high back chair reclined at 45 degrees with a footrest and board was observed in the resident's room. An interview conducted with Employee E6 on April 29, 2026, at 9:50 a.m., revealed that they were the residents' full-time nurses. Employee E6 reported Resident 9 was unable to reposition self but had jerking movements episodes. Employee E6 reported that they assessed Resident 9 after the fall on September 17, 2026. Employee E6 confirmed that the high back chair in the resident's room was the same chair in use when they fell. Employee E6 further stated It's reclined now (pointing at the chair in the room) but it was straight up during the fall because they just finish eating. Employee 6 further stated I don't remember the footrest being there. A review of Resident 9's Rehabilitation Services Screening dated May 5, 2025, revealed Recommend semi-reclining wheelchair for OOB (out of bed) slightly reclined high back and position trunk in midline for comfort. Feet may rest on leg rest calf pads due to reduced knee extension ROM (range of motion). A review of Resident 9's active care plan revealed rehab recommendations for appropriate wheelchair positioning were not added into the residents' plan of care. An interview with the Director of Nursing on April 30, 2026, at 11:00 a.m., confirmed that rehab recommendations for appropriate wheelchair positioning were not reflected in the resident's care plan. The facility failed to ensure Resident 9 care plan was revised to reflect appropriate wheelchair positioning. 28 Pa. Code 211.12(c)(d)(1)(5) Nursing services</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>Based on clinical records review, and staff interview, it was determined that the facility failed to ensure physicians were notified and an intervention was put in place for a significant weight loss for two of two residents reviewed (Resident 27 and 83). Findings: Review of Resident 27's diagnosis includes Dysphagia, oropharyngeal phase (Trouble starting a swallow because the mouth and throat muscles aren't working smoothly, making it hard to move food or liquid from the mouth into the throat) and Type 2 Diabetes (DM- failure of the body to effectively use insulin produced in the body, insulin regulates blood sure to pass from blood stream to cells). A review of Resident 27's clinical records weight and vitals revealed, December 5, 2025, Resident 27 weighed 151.9 pounds and on January 1, 2026, the resident weighed 140.9 pounds a 7.2% weight loss in 27 days. There were no documented evidence indicating that the physician was notified of the significant weight loss and that an intervention was put in place after the significant weight loss was identified until March 7, 2026, Boost Breeze supplementation will increase from BID to TID to support caloric and protein needs. Resident remains at high nutrition risk due to chronic illness, cognitive impairment, and ongoing weight loss. An interview with the Registered Dietician Employee E3 conducted on April 30, 2026, at 1:30 p.m., Employee E3 reported that nursing is responsible for taking Residents weight. Any identified significant weight loss is to be reported to the Registered Dietician by Nursing. Employee E3 confirmed that they were not notified of the residents' significant weight loss on January 1, 2026. There was no documented evidence that Residents physician was notified of the significant weight loss identified on January 1, 2026. Review of Resident 83's diagnosis includes Dysphagia, oropharyngeal phase (Trouble starting a swallow because the mouth and throat muscles aren't working smoothly, making it hard to move food or liquid from the mouth into the throat). A review of Resident 83's clinical records weight and vitals revealed, that on February 28, 2026, Resident 83 was readmitted to the facility, and staff used her hospital weight of 88 pounds. On March 2, 2026, the resident weighed 79.5 pounds, reflecting a 9.7% weight loss in 3 days. Clinical record review revealed that weight was not taken upon readmission and was completed 3 days later. There was no documented evidence indicating that the Physician was notified of the significant weight loss identified March 2, 2026. A review of Resident 83 nutritional monitoring completed by the Registered Dietician on March 7, 2026, identified the resident's weight loss on March 2, 2026. The same notes revealed Resident remains at nutritional risk due to variable oral intake, recent weight fluctuations, and acute medical status following trauma-related injuries and fractures. Weight trends demonstrate a decline from 88 lbs (02/28/2026) to 79.5 lbs (03/02/2026), with historical weights consistently reflecting an underweight BMI (Body Mass Index) status. Oral intake continues to fluctuate from poor to fair across meals, with slightly better intake noted later in the day. Resident remains on a pureed diet (All your food is blended until it's completely smooth like the texture of applesauce, mashed potatoes, or yogurt. No chunks, no seeds, nothing to chew) with thin liquids following recent speech therapy advancement. Nutritional supplements are ordered (Boost BID and Magic Cup daily) to support caloric intake. The same notes revealed that Resident at high nutrition risk due to severe underweight and inadequate intake. Nutrition diagnosis: Severe malnutrition related to poor oral intake as evidenced by BMI 13.35 and <25% meal intake. Plan: Continue pureed diet with assistance, initiate oral nutrition supplement Boost 8 oz BID and Magic Cup daily, encourage fluids, monitor weekly weights. A review of Resident 83's March 2026, Medication Administration Records revealed that the Boost BID and the Majic Cup ordered on October 5, 2025, was discontinued on March 7, 2026. An interview with the Registered Dietician Employee E3 on April 30, 2026, at 1:30 p.m., confirmed that the Boost BID and Majic cup was discontinued due to Resident 83's refusal. A review of residents Medication Administration Record March 2026 revealed that the Majic cup was not administered on March 2, 2026, March 4, 2026, and March 5, 2026, at 8:00 a.m., due to drug/item unavailable. Further Medical Administration Record revealed that Boost 8oz BID was not administered on March 2, 2026, March 4, (continued on next page)</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>2026, March 5, 2026, and March 7, 2026, at 8 a.m. due to drug item/ unavailable. On March 1, 2026, March 2, 2026, March 3, 2026 and March 4, 2026, March 5, 2026, March 6, 2026, and March 7, 2026, the resident at 4:00 p.m. consumed (March 1,2026, 25%, March 2, 2026, 25%, March 3, 2026, 100%, March 4, 2026, 50%, March 5, 2026, 25%, and March 6, 2026, 25% at 4 p.m.)An interview with Employee E3 conducted on April 30, 2026, at 1:30 p.m., confirmed that resident 27 and 83's physician was not notified of the significant weight loss and that the interventions were not put in place. The facility failed to ensure the physician was notified of Resident 27 and 83's significant weight loss and further interventions were put in place to prevent further weight loss timely.28 Pa. Code 211.12(d)(1)(3)(5) Nursing services</p>		