DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396114	(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00 B. WING:	(X3) DATE SURVEY COMPLETED: 04/30/2026

NAME OF PROVIDER OR SUPPLIER: **TWIN PINES HEALTH CARE CENTER** STATE LICENSE NUMBER: **032102**	STREET ADDRESS, CITY, STATE, ZIP CODE: **315 EAST LONDON GROVE ROAD WEST GROVE, PA 19390**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT Based on a Medicare/Medicaid Recertification, State Licensure and Civil Rights Compliance survey completed on April 30, 2026, it was determined that Twin Pines Health Care Center was not in compliance with the following requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care and the 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations as it relates to the Health portion of the survey process.	F 0000		
F 0657 SS=D		F 0657		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE: (X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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F 0657 SS=D	Continued from page 1 483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by:	F 0657	1. On 4/30/26 the care plan for R9 was updated to reflect the appropriate wheel chair positioning with use of high back wheel chair. No negative outcome resulted from deficient practice. 2. All residents who utilize a high back wheel chair have the potential to be affected. DON/ designee completed audit of all residents who use a high back wheel chair to ensure that the recommended use and positioning was reflected on the care plans. Where needed, care plans were updated. 3. To prevent the potential for reoccurrence, the NHA/designee re-educated the IDT team on timely completion of all interdisciplinary plans of care and revisions as indicated by the resident's needs, wishes, or change in condition. 4. To monitor and maintain ongoing compliance, the DON/designee will audit residents with high back wheel chairs x4 weeks, then monthly x2 to	Completion Date: **05/27/2026** Status: **APPROVED** Date: **05/18/2026**

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F 0657 SS=D	Continued from page 2	F 0657	ensure their care plans reflect the use and appropriate positioning of the device. The results of the audit will be forwarded to the facility QAPI committee monthly for further review and recommendations as needed.	

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F 0657 SS=D	Continued from page 3 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	F 0657		

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F 0657 SS=D	Continued from page 4 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.	F 0657		

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F 0657 SS=D	Continued from page 5 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)."	F 0657		

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F 0657 SS=D	Continued from page 6 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	F 0657		

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F 0657 SS=D	Continued from page 7	F 0657		
F 0692 SS=D		F 0692		

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F 0692 SS=D	Continued from page 8 483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by:	F 0692	1. On 4/30/26 the MD was made aware of significant weight losses for R 27 and R 83. Dietitian reviewed R 27 and R83, all interventions reviewed and approved by MD. 2. All resident who have experienced significant weight loss have the potential to be affected, the Dietitian/designee completed a 30 day look back to ensure that all identified significant weight losses had and intervention in place and both weight loss and intervention had been notified to the MD and were reflected in the EHR. Where applicable the notification was completed. 3. To prevent the potential for reoccurrence, the NHA/designee re-educated the IDT team on the facility weight process with an emphasis on timely provider notification of significant weight loss and implementation of interventions. 4. To monitor and maintain ongoing	Completion Date: **05/27/2026** Status: **APPROVED** Date: **05/18/2026**

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F 0692 SS=D	Continued from page 9	F 0692	compliance, the DON/designee will audit residents' weights x 4 weeks, then monthly x2 to ensure any significant weight loss is communicated in a timely manner to the MD with an intervention and documented in the HER. The results of the audit will be forwarded to the facility QAPI committee monthly for further review and recommendations as needed.	

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F 0692 SS=D	Continued from page 10 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.	F 0692		

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F 0692 SS=D	Continued from page 11 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.	F 0692		

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F 0692 SS=D	Continued from page 12 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	F 0692		

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F 0692 SS=D	Continued from page 13 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	F 0692		

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F 0692 SS=D	Continued from page 14 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 8ox BID was not administered on March 2, 2026, March 4, 2026, March 5, 2026, and March 7, 2026, at 8 a.m. due to "drug item/ unavailable". On March 1,	F 0692		

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F 0692 SS=D	Continued from page 15 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	F 0692		

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F 0812 SS=F		F 0812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396114	(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00 B. WING:	(X3) DATE SURVEY COMPLETED: 04/30/2026

NAME OF PROVIDER OR SUPPLIER: **TWIN PINES HEALTH CARE CENTER** STATE LICENSE NUMBER: **032102**	STREET ADDRESS, CITY, STATE, ZIP CODE: **315 EAST LONDON GROVE ROAD WEST GROVE, PA 19390**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0812 SS=F	Continued from page 17 483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:	F 0812	1) Immediately upon being made aware of the concern, the spinach, biscuits, and hamburgers found were all discarded as appropriate. All food that was found to have been stored improperly were immediately discarded as needed. 2) FSD completed an immediate audit of the food items stored in the walk in freezer to ensure foods were properly covered and stored within the walk-in freezer to ensure foods were properly covered and protected from contamination, freezer burn, and or any other issues that can arise from an improperly stored item. No other items were found at the time to have been stored improperly or without proper packaging/storage practices. 3) All Dietary staff was educated on proper food storage practices, facility policy, and the regulation requirements for proper food storage. This included maintain foods in covered contained or sealed packaging, preventing cross	Completion Date: **05/27/2026** Status: **APPROVED** Date: **05/18/2026**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396114	A. BLDG: 00 B. WING:	04/30/2026

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
TWIN PINES HEALTH CARE CENTER STATE LICENSE NUMBER: **032102**	**315 EAST LONDON GROVE ROAD** **WEST GROVE, PA 19390**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0812 SS=F	Continued from page 18	F 0812	contamination, maintaining food quality, and adhering to regulatory requirement and standards. Education also provided on expectations for ongoing monitoring by all staff for freezer storage throughout each shift. 4) The FSD or designee will conduct weekly audits for one month of the walk in freezer to ensure all food is properly stored within the freezer. After one month audits will be conducted once per month to include verification that all food items are properly covered, dated if applicable, and stored to prevent contamination. 5) Findings will be reported to the QAPI committee as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396114	(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00 B. WING:	(X3) DATE SURVEY COMPLETED: 04/30/2026

NAME OF PROVIDER OR SUPPLIER: **TWIN PINES HEALTH CARE CENTER** STATE LICENSE NUMBER: **032102**	STREET ADDRESS, CITY, STATE, ZIP CODE: **315 EAST LONDON GROVE ROAD WEST GROVE, PA 19390**

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F 0812 SS=F	Continued from page 19 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.	F 0812		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396114	(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00 B. WING:	(X3) DATE SURVEY COMPLETED: 04/30/2026

NAME OF PROVIDER OR SUPPLIER: TWIN PINES HEALTH CARE CENTER STATE LICENSE NUMBER: 032102	STREET ADDRESS, CITY, STATE, ZIP CODE: 315 EAST LONDON GROVE ROAD WEST GROVE, PA 19390

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
F 0812 SS=F	Continued from page 20 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.	F 0812		

Pennsylvania Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396114	(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00 B. WING:	(X3) DATE SURVEY COMPLETED: 04/30/2026

NAME OF PROVIDER OR SUPPLIER: **TWIN PINES HEALTH CARE CENTER** STATE LICENSE NUMBER: **032102**	STREET ADDRESS, CITY, STATE, ZIP CODE: **315 EAST LONDON GROVE ROAD WEST GROVE, PA 19390**

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P 5520		P 5520		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE:	(X6) DATE:

Pennsylvania Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396114	(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00 B. WING:	(X3) DATE SURVEY COMPLETED: 04/30/2026

NAME OF PROVIDER OR SUPPLIER: **TWIN PINES HEALTH CARE CENTER** STATE LICENSE NUMBER: **032102**	STREET ADDRESS, CITY, STATE, ZIP CODE: **315 EAST LONDON GROVE ROAD WEST GROVE, PA 19390**

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P 5520	Continued from page 1 Nursing services. (3) Effective July 1, 2024, a minimum of 1 nurse aide per 10 residents during the day, 1 nurse aide per 11 residents during the evening, and 1 nurse aide per 15 residents overnight. This REGULATION is not met as evidenced by:	P 5520	1) Staff was educated on calling off in a timely manner and following all attendance policy and procedure in regards to clocking in and out. 2) Staffing reviewed on each workday to ensure vacant nurse aide shifts are filled to meet the ratio requirements, and the hours set which have been determined by census, and the ratio requirement are accurate, and all efforts are made to replace, fill, and or meet all necessary requirements. 3) Education provided to management staff to ensure that all ratios for nursing aide staffing are adhered to in order to meet the regulated needs based on census. All processes will be reviewed with the management team in regard to utilizing the staffing call list as well as the agency platforms to acquire replacement staff if needed. 4) NHA and or designee to review staffing daily to ensure ratio requirement is met for two weeks	Completion Date: **05/30/2026** Status: **APPROVED** Date: **05/18/2026**

Pennsylvania Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396114	A. BLDG: 00 B. WING:	04/30/2026

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
TWIN PINES HEALTH CARE CENTER STATE LICENSE NUMBER: **032102**	**315 EAST LONDON GROVE ROAD** **WEST GROVE, PA 19390**

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P 5520	Continued from page 2	P 5520	from 5/1/26 until 5/30/26. Ongoing monthly reviews will be conducted to ensure all staffing minimums are met. All findings will be reported to the QAPI committee for continued review and revision.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396114	(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00 B. WING:	(X3) DATE SURVEY COMPLETED: 04/30/2026

NAME OF PROVIDER OR SUPPLIER: **TWIN PINES HEALTH CARE CENTER** STATE LICENSE NUMBER: **032102**	STREET ADDRESS, CITY, STATE, ZIP CODE: **315 EAST LONDON GROVE ROAD WEST GROVE, PA 19390**

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P 5520	Continued from page 3 Based on review of facility staffing data, it was determined that the facility failed to ensure a minimum of one nurse aide per 10 residents on day shift for one of three weeks of facility staffing reviewed (weeks of September 7, 2025, December 28, 2025, and April 27, 2026). Findings include: Review of the weeks of September 4, 2025, December 24, 2025, and March 26, 2026, revealed the following dates on day shift did not meet the requirement of one nurse aide per 10 residents: December 29, 2025, and December 31, 2025. Interview conducted with Nursing Home Administrator (NHA) on April 31, 2026, , 2026, at 2:15 p.m., when the above was presented, the NHA confirmed nurse aide staffing ratios were not met on these days.	P 5520		

Pennsylvania Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396114	A. BLDG: 00 B. WING:	04/30/2026

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
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P 5520	Continued from page 4	P 5520		
P 5530		P 5530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396114	(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00 B. WING:	(X3) DATE SURVEY COMPLETED: 04/30/2026

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P 5530	Continued from page 5 Nursing services. (4) Effective July 1, 2023, a minimum of 1 LPN per 25 residents during the day, 1 LPN per 30 residents during the evening, and 1 LPN per 40 residents overnight. This REGULATION is not met as evidenced by:	P 5530	1) Staff was educated on calling off in a timely manner and following all attendance policy and procedure in regards to clocking in and out. 2) Staffing reviewed daily to ensure vacant shifts are filled to meet the ratio requirements, and the hours set which have been determined by census and the ratio requirement are accurate and all efforts are made to replace, fill, and or meet all necessary requirements. 3) Education provided to management staff to ensure that all hours, ratios, and ppd are adhered to in order to meet the regulated needs based on census. All processes will be reviewed with the management team in regard to utilizing the staffing call list as well as the agency platforms to acquire replacement staff if needed. 4) NHA and or designee to review staffing daily to ensure LPN ratio requirement is met for two weeks from 5/1/26 until 5/30/26. Ongoing	Completion Date: **05/30/2026** Status: **APPROVED** Date: **05/18/2026**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396114	(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00 B. WING:	(X3) DATE SURVEY COMPLETED: 04/30/2026

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P 5530	Continued from page 6	P 5530	monthly reviews will be conducted to ensure all staffing LPN minimum hours are met. All findings will be reported to the QAPI committee for continued review and revision.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396114	(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00 B. WING:	(X3) DATE SURVEY COMPLETED: 04/30/2026

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P 5530	Continued from page 7 Based on review of facility staffing data, it was determined that the facility failed to ensure a minimum of one licensed practical nurse per 25 residents on day shift for three of three weeks of facility staffing reviewed (Weeks of September 7, 2025, and December 28, 2025, and April 27, 2026). Findings include: Review of the weeks of September 7, 2025, December 28, 2025, and April 27, 2026, revealed the following dates on dayshift did not meet the requirement of one licensed practical nurse (LPN) per 25 residents during day shift: September 7, 2025, September 13, 2025, December 28, 2025, December 29, 2025, December 31, 2025, April 25, 2026, and April 26, 2026. Interview with Nursing Home Administrator (NHA) on April 31, 2026, at 2:15 p.m., when the NHA	P 5530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396114	(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00 B. WING:	(X3) DATE SURVEY COMPLETED: 04/30/2026
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P 5530	Continued from page 8 confirmed that the LPN staffing ratios were not met on the above days.	P 5530		
P 5640		P 5640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396114	(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00 B. WING:	(X3) DATE SURVEY COMPLETED: 04/30/2026

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P 5640	Continued from page 9 Nursing services. (2) Effective July 1, 2024, the total number of hours of general nursing care provided in each 24-hour period shall, when totaled for the entire facility, be a minimum of 3.2 hours of direct resident care for each resident. This REGULATION is not met as evidenced by:	P 5640	1) Staff was educated on calling off in a timely manner and following all attendance policy and procedure in regard to clocking in and out. 2) Staffing reviewed daily to ensure vacant shifts are filled to meet the PPD requirements which have been determined by census, and all efforts are made to replace, fill, and or meet all necessary PPD requirements. 3) Education provided to management staff to ensure that all hours, ratios, and ppd are adhered to in order to meet the regulated needs based on census. All processes will be reviewed with the management team in regard to utilizing the staffing call list as well as the agency platforms to acquire replacement staff if needed. 4) NHA and or designee to review staffing daily to ensure PPD requirement is met for two weeks from 5/1/26 until 5/30/26. Ongoing monthly reviews will be conducted to ensure all staffing minimums are	Completion Date: **05/30/2026** Status: **APPROVED** Date: **05/18/2026**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396114	(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00 B. WING:	(X3) DATE SURVEY COMPLETED: 04/30/2026

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P 5640	Continued from page 10	P 5640	met. All findings will be reported to the QAPI committee for continued review and revision.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396114	(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00 B. WING:	(X3) DATE SURVEY COMPLETED: 04/30/2026

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P 5640	Continued from page 11 Based on review of facility staffing, it was determined that the facility failed to ensure the total number of general nursing care hours provided in each 24-hour period was a minimum of 3.20 hours per patient day (PPD) for four of twenty-one days of staffing reviewed (weeks of September 7, 2025, and December 28, 2025. Findings include: Review of facility staffing revealed the following dates were below 3.20 hours PPD: September 13, 2025, with a PPD of 3.15. December 29, 2025, with a PPD of 2.99. December 31, 2025, with a PPD of 3.03. January 3, 2026, with a PPD of 3.14. Interview conducted with Nursing Home Administrator (NHA) on April 31, 2026, at 2:15 p.m., when the above was presented, the NHA confirmed PPD staffing ratios were not met on these days.	P 5640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396114	(X2) MULTIPLE CONSTRUCTION: A. BLDG: 00 B. WING:	(X3) DATE SURVEY COMPLETED: 04/30/2026

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P 5640	Continued from page 12	P 5640		

Certified End Page

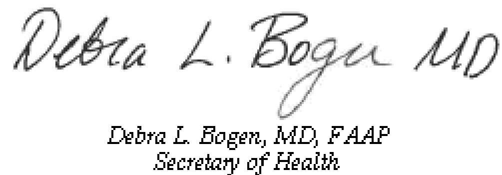
TWIN PINES HEALTH CARE CENTER

STATE LICENSE NUMBER: 032102

SURVEY EXIT DATE: 04/30/2026

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeanne Parisi
Deputy Secretary for Quality Assurance



Debra L. Bogen, MD, FAAP
Secretary of Health

Pennsylvania
Department of Health

THIS IS A CERTIFICATION PAGE

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