

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395566	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/06/2024
NAME OF PROVIDER OR SUPPLIER Highland Manor Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 750 Schooley Avenue Exeter, PA 18643	

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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>48277</p> <p>Based on review of minutes from the Residents' Council meeting and resident and staff interviews it was determined that the facility failed to provide care in a manner and environment, which promotes each resident's quality of life, by failing to respond timely to residents' request for assistance as evidenced by experiences reported by five residents out of five sampled (Residents 14, 11, 9, 13 and 10).</p> <p>Findings include:</p> <p>During interviews conducted throughout the day tour of duty on March 6, 2024, the residents stated that they feel the facility is not adequately staffed because they wait extended periods of time for staff to respond to their requests for assistance, including untimely responses to their requests via the nurse call bell system.</p> <p>A review of minutes from the Residents' Council meeting on February 1, 2024, revealed that Resident 14 was requesting staff assignments be reassessed as he has been left in the bathroom for long periods of time when his assigned aide is off the floor. He reported that staff tell him they do not have him on their assignment and do not provide the necessary assistance, which has caused him to wait extended periods of time in the bathroom.</p> <p>Interview with Resident 11 on March 6, 2024, at 10:43 AM revealed that she feels that short staffing and agency nursing staff are a problem in the facility. She stated that over that last couple of days I would ring the bell to use the bathroom because I can't do it myself. I had to wait over an hour. I couldn't hold it and, unfortunately, I soiled myself.</p> <p>(continued on next page)</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview with Resident 9 on March 6, 2024, at 11:15 AM, revealed that she has waited over 2 hours for staff to answer her call bell. The resident stated that these long waits often occur an hour or so around shift changes. Resident 9 reported that on March 4, 2024, she was put in bed at 7:30 PM. At 1:00 AM an aide came in to check if the resident needed to be changed, and the resident replied that she did not at that time. Resident 9 stated she woke at 5:00 AM and activated the call bell as she needed to use the bathroom at that time. No one answered her call bell until 6:20 AM, when an aide peeked in the resident's room and said she would tell the other girls that she needed to be changed. Resident 9 stated that she soiled herself waiting for staff assistance. It was not until 7:30 AM, 2.5 hours after Resident 9 activated her call bell for assistance, that a nurse aide came in the resident's room to provide assistance. Resident 9 stated that she was so saturated with urine by that time that they had to change all the bed linens. She stated, I was so embarrassed, but I couldn't help it, I had to go.</p> <p>Interview with Resident 13 on March 6, 2024, at 11:30, revealed that the resident stated he has learned to do everything for himself because staff take forever to answer the call bell and provide assistance when needed.</p> <p>Interview with Resident 10 on March 6, 2024, at 12:00 PM, revealed that he has waited over an hour for staff to answer his call bell. The resident stated that these waits occur mostly on 2nd shift (evening shift). He further stated he feels that short staffing is a problem in the facility that creates these long waits for residents to receive personal care and assistance when requested from nursing staff.</p> <p>Interview on March 6, 2024, at approximately 2:15 PM with the Director of Nursing (DON) verified that it is her expectation that all residents be treated with dignity and respect. The DON was unable to explain why multiple residents are reporting untimely staff response times to their call bells and requests for assistance, resulting in the residents' feelings that the facility is not adequately staffed, which was negatively affecting the residents' quality of life in the facility.</p> <p>28 Pa. Code 201.18 (e)(1) Management</p> <p>28 Pa. Code 201.29 (a) Resident Rights</p> <p>28 Pa. Code 211.12 (c)(d)(4)(5) Nursing Services</p>		

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<p>F 0807</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration.</p> <p>48277</p> <p>Based on observation, review of clinical records and select facility policy, and resident and staff interviews, it was determined that the facility failed to ensure fresh water was consistently readily accessible to residents to promote adequate hydration, resident preference and comfort for five out of 14 residents reviewed (Residents 11, 9, 12, 13, and 2).</p> <p>Findings include:</p> <p>A review of the facility policy titled Water Pass provided by the facility on March 6, 2024, indicated that the facility will provide the residents with fresh water every shift and that straws, cups, and lids are changed at a minimum of every three days.</p> <p>During an interview with Resident 11 on March 6, 2024, at 10:43 AM, the resident expressed frustration that she has to consistently ask staff to provide fresh drinking water, and staff do not routinely provide fresh drinking water daily. She stated you have to ask for it, and even then, they're so busy, they forget. My son got me a cup yesterday, but no staff member has been in to give me any (fresh water) since then.</p> <p>During an interview with Resident 9 on March 6, 2024, at 11:15 AM, she reported that staff do not provide fresh drinking water every shift and that the only drinking water she receives is the one she gets on her breakfast tray. She stated, I have to ask them every day for 1/2 cup of ice. Observation at the time of the interview revealed a Styrofoam cup with lid and straw in it on which on the side of the cup was written the resident's room number and bed location (A or B) dated February 29, 2024.</p> <p>During an observation in Resident 12's room on March 6, 2024, at 11:25 AM, revealed a Styrofoam cup with lid and straw in it on the nightstand, out of reach of the resident on which was written, on the side of the cup, the resident's room number, bed location, and the date of February 29, 2024.</p> <p>During an interview with Resident 13 on March 6, 2024, at 11:30 AM, he reported that I get it (fresh water) myself. No one comes in to give me fresh water, so I go across the hall and get it myself. Observation at the time of the interview revealed a Styrofoam cup with a lid and straw in it, on which was written, on the side of the cup, the resident's room number, bed location, and date of February 29, 2024.</p> <p>During an interview with Employee 1 (nurse aide) on March 6, 2024, at 11:35, she confirmed that the Styrofoam cups for drinking water, observed in the rooms of Residents 11, 12, and 13 were dated six days ago, February 29, 2024, and that Resident 12's cup was also out of the resident's reach.</p> <p>Observation in Resident 2's room on March 6, 2024, at 11:45 AM, revealed no water cup or other beverage available to the resident. Review of Resident 2's care plan revealed that the resident was on a regular diet with thin liquids and was independent with self-feeding.</p> <p>(continued on next page)</p>		

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<p>F 0807</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview with Employee 2 (licensed practical nurse) on March 6, 2024, at 11:48 AM, confirmed that Resident 2 was independent with drinking thin liquids and able to manipulate the water cup independently. She also confirmed the absence of fresh water or another beverage available to Resident 2.</p> <p>During an interview on March 6, 2024, at approximately 12:40 PM, the Director of Nursing (DON) stated that it is facility policy that the water pass is to be conducted once per shift and as needed. The DON stated it is facility policy to change straws, cups and lids every three days and as needed. The NHA confirmed that the facility failed to provide clean water drinking cups every three days and failed to demonstrate that fresh ice water was readily accessible as preferred by residents to promote adequate and hydration and comfort for residents.</p> <p>28 Pa. Code 211.12 (d)(3)(5) Nursing services.</p>