

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 06/18/2025
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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, resident grievances, observations, and resident and staff interviews, it was determined the facility failed to provide care in a manner that promotes and enhances each resident's dignity and quality of life by failing to respond in a timely manner to residents' requests for assistance for 5 residents out of 10 sampled. (Residents CR1, 2, 3, 4, and 5).</p> <p>Findings include:</p> <p>A review of a grievance filed with the facility by the daughter of Resident CR1, dated April 9, 2025, revealed that Resident CR1 had a bowel movement in her brief and required staff assistance for hygiene care. She activated her call bell at 9:41 AM requesting assistance. Facility records indicated that by 11:41 AM no staff had responded to the call bell, and as of 12:00 PM she remained unchanged. Resident CR1 was ultimately provided incontinence care at 12:30 PM, approximately three hours after her initial request for assistance. The grievance documentation indicated the daughter informed the nurse on duty, who stated that someone would respond; however, timely care was not provided. Facility records show that the facility acknowledged to the daughter that the excessive delay in responding to the request for assistance was not acceptable and that she should notify the supervisor immediately if delays occur.</p> <p>An interview with Resident CR1 and her daughter could not be completed during the survey</p> <p>During an interview with Resident 2 on June 18, 2025, at 10:45 AM she reported she frequently has waited over an hour for staff to answer her call bell. She stated, I've soiled myself so many times waiting for them to come, I've lost count, and added Supper time is the worst. They don't come, so I had to stop asking.</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>During an observation on June 18, 2025, at 10:55 AM in room [ROOM NUMBER], there was a strong odor of BM (bowel movement) permeating throughout the room. Resident 5 was observed lying in bed uncovered, with a visibly soiled brief. Bowel movement matter was observed to be leaking out of the sides of the brief, soiling the bedsheet underneath. Resident 5's call bell was activated at 10:55 AM. The call bell alert light was visible above the resident's doorway. At 11:10 AM Employee 1 (Occupational Therapist) entered Resident 5's room. The call bell light was turned off and Employee 1 exited the room without providing care. At 11:14 AM the call light was activated again with the resident yelling help me. At 11:25 AM the Activities Director entered the room, turned off the call bell, and told the resident Someone will be right in. Employee 2 exited the room and did not provide the required care. At 11:30 AM, 35 minutes after the resident first activated the call bell, a nurse aide entered the room to provide assistance for incontinence.</p> <p>During an interview with Resident 3 on June 18, 2025, at 11:40 AM, he stated he has often waited over an hour for staff to respond to his call bell. He reported that staff frequently enter his room, turn off the call bell light, and leave without providing assistance, stating they would return but often do not return for another hour or longer. He indicated that such delays occur more frequently during early morning and second shifts.</p> <p>During an interview with Resident 4 on June 18, 2025, at 12:00 PM she stated the first weekend after she was admitted (June 7-8, 2025), for staff to respond to her call bell while needing to use the bathroom She stated she was almost in tears and desperately needed to use the bathroom. She also reported this past weekend (June 14-15, 2025) she waited over one hour for staff assistance after she activated her call bell. She stated a nurse finally came in after an hour but did not assist her to the restroom. Instead, the nurse started yelling for the aides. She expressed frustration the nurse would not provide the assistance but instead had to continue to wait for a nurse aide to become available.</p> <p>During an interview on June 18, 2025, at approximately 1:00 PM, the Nursing Home Administrator (NHA) and the Director of Nursing (DON) acknowledged that the residents should not have to wait extended periods of time for staff to answer call bells. The DON verified that staff are not to turn off the call bell light until care is provided.</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 (d)(1)(3)(4) Nursing services.</p>		