STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395566	A. Building B. Wing	05/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Manor Rehabilitation and Nursing Center	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)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of clinical records, select facility policy, and resident and staff interviews, it was determined the facility failed to provide nursing services consistent with professional standards of practice by failing to ensure a Licensed Practical Nurse (LPN) timely monitored, recognized, communicated, intervened, and obtained appropriate supervisory assistance when a resident experienced a blocked indwelling urinary catheter (a flexible sterile tube inserted into the urinary bladder to drain urine) for one of 10 residents reviewed (Resident 9).Findings include: The Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.145 Functions of the Licensed Practical Nurse (LPN) (a) The LPN is prepared to function as a member of the health-care team by exercising sound nursing judgment based on preparation, knowledge, experience in nursing and competency. The LPN participates in the planning, implementation and evaluation of nursing care using focused assessment in settings where nursing takes place. (1) An LPN shall communicate with a licensed professional nurse and the patient's health care team members to seek guidance when: (ii) The patient's care needs surpass the LPN's knowledge, skill or ability. (iii) The patient's condition deteriorates or there is a significant change in condition, the patient is not responding to therapy, the patient becomes unstable or the patient needs immediate assistance. (2) An LPN shall obtain instruction and supervision if implementing new or unfamiliar nursing practices or procedures. (3) An LPN shall follow the written, established policies and procedures of the facility that are consistent with the act. Review of the facility policy titled Catheter Care, Urinary last reviewed by the facility on February 19, 2026, indicated staff were to change urinary catheters and drainage bags based on clinical indications such as obstruction (blockage). The policy directed staff to observe the resident for complications associated with urinary catheters and immediately report unusual findings to the physician or supervisor, including when the resident complained of bladder fullness, inability to void (urinate), abdominal discomfort, urinary retention, pain, or signs of catheter obstruction. Review of the clinical record revealed Resident 9 was admitted to the facility on [DATE], with diagnosis to include retention of urine (the inability to completely empty the bladder or the complete inability to pass urine) and benign prostatic hyperplasia with lower urinary tract symptoms (noncancerous enlargement of the prostate gland causing obstruction of urinary flow and urinary systems such as issues with urination, bladder emptying and storage). Review of Resident 9's quarterly Minimum Data Set Assessment (MDS, a federally mandated standardized assessment conducted at specific intervals to plan resident care) dated May 8, 2026, indicated Resident 9 was cognitively intact with a BIMS score of 15 (Brief Interview for Mental Status, a tool within the Cognitive Section of the MDS that is used to assess the resident's attention, orientation, and ability to register and recall new information; a score of 13 through 15 indicates intact cognition). Review of a care plan dated March 30, 2026, revealed Resident 9 utilized a coude catheter (a specialized urinary catheter featuring a slightly curved or bent tip, designed to bypass urethral obstruction. A standard catheter has a straight tip, a coude catheter's curved tip allows it to bypass anatomical blockages rather than poking directly into them and are commonly used for residents with enlarged prostate glands). Review of physician orders dated March 27, 2026, directed staff to flush the indwelling catheter (inject sterile saline solution through the (continued on next page)

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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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	catheter tube into the bladder to clear blockages and maintain unobstructed urine flow) with 60 cc (measurement of liquid volume) normal saline as needed for blockage and/or leakage and to change the indwelling catheter and drainage bag as needed. Review of nurse documentation dated May 7, 2026, at 7:10 AM revealed Resident 9 complained of penile pressure and abdominal discomfort. Documentation indicated the indwelling catheter had zero urine output (no urine noted in the drainage bag), the resident's abdomen was distended and firm, and the resident grimaced during abdominal assessment. Documentation further revealed the resident stated, I told night shift about it and was told, nothing could be done until day shift comes in. Nursing documentation indicated attempts to flush the indwelling catheter were unsuccessful due to blockage.Review of nurse documentation dated May 7, 2026, at 9:30 AM revealed the resident's newly inserted indwelling catheter drained 900 cc of yellow urine (normal bladder capacity is between 400-600 cc). The resident stated, Thank you kindly for helping me. Review of nurse documentation dated May 7, 2026, at 1:34 PM revealed a #14/10 cc (size of catheter) coude catheter was inserted at 8:45 AM without difficulty and draining clear yellow urine. The resident verbalized total relief after the procedure. During an interview on May 27, 2026, at 11:35 AM, Resident 9 stated that sometime after midnight on May 7, 2026, he informed nursing staff that he was experiencing abdominal pain and penile pressure like I've never experienced before. The resident stated staff told him, We don't do that on this shift and informed him he would need to wait until day shift arrived. During an interview on May 27, 2026, at 12:10 PM, Employee 1 (Licensed Practical Nurse) stated she received report (detailed briefing) from the night shift nurse, Employee 2 (Licensed Practical Nurse) on May 7, 2026, at the beginning of the 7:00 AM -3:00 PM shift. Employee 1 stated the only information communicated regarding Resident 9 was that the resident's bed was wet. Employee 1 stated she questioned whether any evaluation or intervention had been attempted and Employee 2 did not provide additional information. Employee 1 stated shortly after beginning her shift, a nurse aide informed her Resident 9 was in pain. Upon assessment, Employee 1 observed that the resident's bed was wet, the resident appeared to be in obvious pain, and he grimaced during abdominal palpation (pressing on the stomach area). Employee 1 stated she attempted to flush the catheter but met resistance and was unable to clear the obstruction. Employee 1 removed the catheter and attempted reinsertion of the coude catheter but was unsuccessful. Employee 1 then contacted the unit manager for assistance, who successfully inserted a new coude catheter, resulting in drainage of 900 cc of urine from the resident's bladder. During an interview on May 27, 2026, at 12:29 PM, the Director of Nursing stated nursing staff were expected to monitor and document catheter output each shift. The Director of Nursing stated that when a catheter obstruction is suspected, staff should evaluate catheter function, attempt catheter flushing per physician orders, and if unsuccessful, replace the catheter or perform a bladder scan (a non-invasive ultrasound procedure used to measure the amount of urine retained in the bladder). The Director of Nursing further stated the expectation was for the night shift LPN to notify and obtain assistance from the RN supervisor if the nurse was not comfortable managing the resident's coude catheter. The Director of Nursing confirmed Employee 2, the night shift LPN reported she was not comfortable changing the resident's coude catheter due to lack of familiarity and experience with that type of catheter and waited until day shift arrived rather than notifying the RN supervisor or obtaining assistance. The Director of Nursing further confirmed the Employee 2 LPN received re-education regarding the expected process; however, no formal competency validation or education related to catheter management or coude catheter care was completed. The facility failed to ensure Employee 2, the night shift LPN followed professional standards of nursing practice and facility policy by failing to recognize and respond to Resident 9's complaints of abdominal pain, penile pressure, abdominal distention (swelling caused by pressure within the abdomen), and absence of urinary output; failing to communicate the resident's change in condition and obtain assistance from the RN supervisor when the resident's care needs exceeded the LPN's knowledge, skill, and experience with coude catheter management; and failing to implement timely interventions for a blocked catheter, resulting in delayed (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	treatment and prolonged resident discomfort. Refer to F726 28 Pa. Code 211.10 (c) Resident care policies.28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, facility documentation, and staff interview, it was determined the facility failed to ensure licensed nursing staff possessed and demonstrated the appropriate competencies and skill sets to safely assess, manage, and provide care for residents requiring a coude catheter (a specialized urinary catheter with a curved tip used for residents with urinary obstruction and enlarged prostate) for 5 of 5 licensed nurses reviewed (Employees 1, 2, 3, 4, and 5).Findings include: Review of the clinical record revealed Resident 9 was admitted to the facility on [DATE], with diagnosis to include retention of urine (the inability to completely empty the bladder or the complete inability to pass urine) and benign prostatic hyperplasia with lower urinary tract symptoms (noncancerous enlargement of the prostate gland causing urinary obstruction and impaired bladder emptying). Review of a care plan dated March 30, 2026, revealed Resident 9 required the use of a coude catheter. Review of nurse documentation dated May 7, 2026, and interview with the Director of Nursing (DON) on May 27, 2026, revealed Resident 9's coude catheter became obstructed during the night shift. The night shift Licensed Practical Nurse, Employee 2 (LPN) informed the resident that he would need to wait until the day shift staff arrived for the catheter to be changed. During the interview, the DON stated Employee 2 reported she was not comfortable changing the resident's coude catheter due to lack of familiarity and experience with that type of catheter. Employee 2 did not notify the RN supervisor or seek assistance to ensure timely catheter intervention for the resident. Review of the facility documentation titled Skilled Nursing Competency Training revealed a list of competencies for licensed practical nurses. The list included nephrostomy tube (a thin, flexible catheter inserted through the skin of the lower back directly into the kidney to drain urine) and suprapubic catheters (a flexible medical tube surgically inserted directly into the bladder through a small incision in the lower abdomen that continuously drains urine); however, the facility did not include competency training, return demonstration, or skills validation for Foley catheter insertion, Foley catheter management or the more specialized, coude catheter care and replacement. During interviews on May 27, 2026, between 2:10- 2:30 PM, four licensed nurses employed by the facility (Employees 1, 3, 4, and 5) stated they had received general catheter education during nursing school and had prior experience with coude catheters at previous employers. However, all four nurses reported the facility had not provided facility-specific education, training, competency evaluation or skills validation related to the care, evaluation, insertion, replacement or management of coude catheters. During an interview on May 27, 2026, at 2:45 PM, the DON was unable to provide documented evidence that the facility ensured licensed nursing staff completed education, training, competency evaluations, or demonstrated proficiency for Foley catheter care or specialized coude catheter management. Refer F65828 Pa Code 201.20(a)(6)(d) Staff development.