

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395566</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: __-_____ B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>12/10/2024</b>
NAME OF PROVIDER OR SUPPLIER: <b>HIGHLAND MANOR REHABILITATION AND NURSING CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>750 SCHOOLEY AVENUE EXETER, PA 18643</b>		
STATE LICENSE NUMBER: <b>340902</b>				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
E 0000	INITIAL COMMENT  Based on an Emergency Preparedness Survey completed on December 10, 2024, at Highland Manor Rehabilitation and Nursing Center, it was determined there were no deficiencies identified with the requirements of 42 CFR 483.73.	E 0000		

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.



# Certified End Page

**HIGHLAND MANOR REHABILITATION AND NURSING CENTER**

**STATE LICENSE NUMBER: 340902**

**SURVEY EXIT DATE: 12/10/2024**

**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

**PLEASE DO NOT DETACH**

THIS PAGE IS NOW PART OF THIS SURVEY

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K 0000	<p>INITIAL COMMENT</p> <p>Facility ID# 340902 Component 01 Main Building</p> <p>Based on a Medicare/Medicaid Recertification Survey completed on December 10, 2024, it was determined that Highland Manor Rehabilitation and Nursing Center was not in compliance with the following requirements of the Life Safety Code for an existing health care occupancy. Compliance with the National Fire Protection Association's Life Safety Code is required by 42 CFR 483.70(a).</p> <p>This is a one story, Type III (200), unprotected, ordinary building, with a partial basement, that is fully sprinklered.</p>	K 0000		

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K 0293  SS=E	NFPA 101 Exit Signage  Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.)  This REQUIREMENT is not met as evidenced by:	K 0293	- The illuminated exit signage by B side nurses' station was moved to provide visibility. - The exit signage throughout the facility was assessed to ensure exit signage is not obscured. - Maintenance Director will be educated by NHA/designee to ensure illuminated exit signages are visible and unobscured. - Illuminated exit signage will be randomly audited monthly x3 by Maintenance Director/designee to ensure signage is unobscured and visible. Trends will be reviewed at QAPI monthly.	Completion Date: <b>01/14/2025</b> Status: <b>APPROVED</b> Date: <b>12/17/2024</b>

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K 0293  SS=E	Continued from page 2  Based on observation and interview, it was determined the facility failed to maintain exit signage in one location, affecting one of two floors.  Findings include:  1. Observation on December 10, 2024, at 11:35 a.m., revealed illuminated exit signage, located at the B Hall Nurse's Station, was partially obscured by a ceiling mirror.  Exit interview with the Facility Administrator, Facilities Manager, and Regional Facilities Manager on December 10, 2024, between 12:20 p.m., and 12:35 p.m., confirmed the exit signage deficiency.	K 0293		
K 0321  SS=E		K 0321		



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K 0321  SS=E	Continued from page 4  This REQUIREMENT is not met as evidenced by:	K 0321		

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K 0321  SS=E	Continued from page 5  Based on observation and interview, it was determined the facility failed to maintain hazardous area enclosures in two locations, affecting one of two floors.  Findings include:  1. Observation on December 10, 2024, between 11:38 a.m., and 11:48 a.m., revealed the following:  a. 11:38 a.m., the storage room door located within the Building Services Corridor was held open by unapproved means (tied open). b. 11:48 a.m., the Laundry door required adjustment to fully latch.  Exit interview with the Facility Administrator, Facilities Manager, and Regional Facilities Manager on December 10, 2024, between 12:20 p.m., and 12:35 p.m., confirmed the hazardous area enclosure deficiencies.	K 0321		

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K 0353  SS=E	<p>NFPA 101 Sprinkler System - Maintenance and Testing</p> <p>Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.</p> <p>a) Date sprinkler system last checked _____</p> <p>b) Who provided system test _____</p> <p>c) Water system supply source _____</p> <p>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25</p> <p>This REQUIREMENT is not met as evidenced by:</p>	K 0353	<ul style="list-style-type: none"> <li>- The sprinkler head assemblies located in the laundry area were immediately cleaned and free of lint.</li> <li>- The sprinkler head assemblies throughout the facility were checked to ensure clean and free of debris.</li> <li>- Maintenance Director will be educated by NHA to ensure sprinkler head assemblies are clean and free of debris.</li> <li>- The sprinkler head assemblies will be randomly audited by the maintenance director to ensure the sprinkler head assemblies are clean and free of debris. Trends will be reviewed at QAPI meeting monthly.</li> </ul>	<p>Completion Date: <b>01/14/2025</b></p> <p>Status: <b>APPROVED</b></p> <p>Date: <b>12/17/2024</b></p>

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K 0353  SS=E	Continued from page 7  Based on observation and interview, it was determined the facility failed to maintain the automatic sprinkler system in one instance, affecting one of two floors.  Findings include:  1. Observation on December 10, 2024, at 11:58 a.m., revealed automatic sprinkler head assemblies, located within Laundry, were "loaded" with lint.  Exit interview with the Facility Administrator, Facilities Manager, and Regional Facilities Manager on December 10, 2024, between 12:20 p.m., and 12:35 p.m., confirmed the automatic sprinkler system deficiency.	K 0353		
K 0712  SS=C		K 0712		

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K 0712  SS=C	Continued from page 8  NFPA 101 Fire Drills  Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7  This REQUIREMENT is not met as evidenced by:	K 0712	- Unable to correct the 10 out of 12 fire drills conducted within 1 week of one another. - Fire drills will be conducted on different days and times throughout the year. - NHA will educate Maintenance Director/designee to ensure fire drills are conducted at least quarterly on each shift on different days and times throughout the year. - Fire drills will be audited monthly x3 by Maintenance Director/designee to ensure drills are completed at least quarterly on each shift on different days and times throughout the year. Trends will be reviewed at QAPI meeting monthly.	Completion Date: <b>01/14/2025</b> Status: <b>APPROVED</b> Date: <b>12/17/2024</b>

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K 0712  SS=C	Continued from page 9  Based on documentation review and interview, it was determined the facility failed to maintain fire drills, affecting two of two floors.  Findings include:  1. Observation on December 10, 2024, at 11:20 a.m., revealed ten of twelve required fire drills were conducted within one week of one another.  Exit interview with the Facility Administrator, Facilities Manager, and Regional Facilities Manager on December 10, 2024, between 12:20 p.m., and 12:35 p.m., confirmed the fire drill deficiencies.	K 0712		
K 0741  SS=E		K 0741		

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K 0741  SS=E	Continued from page 10  NFPA 101 Smoking Regulations  Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4  This REQUIREMENT is not met as evidenced by:	K 0741	- The cigarette butts were immediately removed from the trash bin. A noncombustible receptacle, with self-closing lid was provided by the smoking area to empty ashtrays. - The facility will be assess to ensure no other trash receptacles are used to discard cigarette waste. - Staff will be educated by Maintenance Director/designee on proper disposal of cigarette butts. Maintenance Director will be educated by NHA/designee to ensure proper receptacles are available by the smoking area. - Smoking area will be audited monthly x3 by maintenance director/designee to ensure cigarette butts are disposed of properly and proper receptacles are available by the smoking area.	Completion Date: <b>01/14/2025</b> Status: <b>APPROVED</b> Date: <b>12/17/2024</b>

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K 0741  SS=E	Continued from page 11  Based on observation and interview, it was determined the facility failed to maintain smoking regulations in one location, affecting one of two floors.  Findings include:  1. Observation on December 10, 2024, at 12:07 p.m., revealed cigarette butts were located within a trash receptacle at the outdoor smoking location. In addition, the area lacked a noncombustible receptacle, with self-closing lid, into which ashtrays can be emptied.  Exit interview with the Facility Administrator, Facilities Manager, and Regional Facilities Manager on December 10, 2024, between 12:20 p.m., and 12:35 p.m., confirmed the smoking regulations deficiency.	K 0741		
K 0761  SS=C		K 0761		

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K 0761  SS=C	Continued from page 12  NFPA 101 Maintenance, Inspection & Testing - Doors  Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80)  This REQUIREMENT is not met as evidenced by:	K 0761	- The fire doors were inspected and documented. - Fire doors will be inspected per regulation - Maintenance Director will be educated on fire door inspection by NHA/designee. - Audit of fire door inspection will be conducted by maintenance director annually. Trends will be reviewed at QAPI meeting.	Completion Date: <b>01/14/2025</b> Status: <b>APPROVED</b> Date: <b>12/17/2024</b>

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K 0761  SS=C	Continued from page 13  Based on documentation review and interview, it was determined the facility failed to maintain fire doors, affecting two of two floors.  Findings include:  1. Observation on December 10, 2024, at 11:24 a.m., revealed the facility lacked fire door inspection data for the previous twelve-month period (last performed 3/23).  Exit interview with the Facility Administrator, Facilities Manager, and Regional Facilities Manager on December 10, 2024, between 12:20 p.m., and 12:35 p.m., confirmed the fire door deficiency.	K 0761		
K 0918  SS=C		K 0918		

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K 0918  SS=C	Continued from page 14  NFPA 101 Electrical Systems - Essential Electric System  Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10	K 0918	<ul style="list-style-type: none"> <li>- Unable to correct missing generator battery voltage readings.</li> <li>- Batter voltage reading will be conducted weekly.</li> <li>- Maintenance Director will be educated generator battery voltage readings and documentation of same.</li> <li>- Generator battery voltage readings will be audited monthly by maintenance director/designee to ensure voltage is accurate and documented. Trends will be reviewed at QAPI meeting monthly.</li> </ul>	Completion Date: <b>01/14/2025</b> Status: <b>APPROVED</b> Date: <b>12/17/2024</b>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395566</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>12/10/2024</b>	
NAME OF PROVIDER OR SUPPLIER: <b>HIGHLAND MANOR REHABILITATION AND NURSING CENTER</b>  STATE LICENSE NUMBER: <b>340902</b>		STREET ADDRESS, CITY, STATE, ZIP CODE: <b>750 SCHOOLEY AVENUE EXETER, PA 18643</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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
K 0918  SS=C	Continued from page 15  (NFPA 70)  This REQUIREMENT is not met as evidenced by:  Based on documentation review and interview, it was determined the facility failed to maintain the generator set in one instance, affecting two of two floors.  Findings include:  1. Observation on December 10, 2024, at 11:28 a.m., revealed the facility lacked weekly battery voltage readings.  Exit interview with the Facility Administrator, Facilities Manager, and Regional Facilities Manager on December 10, 2024, between 12:20 p.m., and 12:35 p.m., confirmed the generator set deficiency.	K 0918		



# Certified End Page

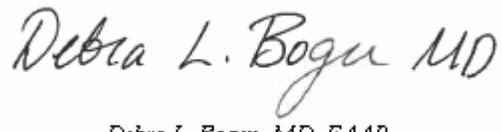
**HIGHLAND MANOR REHABILITATION AND NURSING CENTER**

**STATE LICENSE NUMBER: 340902**

**SURVEY EXIT DATE: 12/10/2024**

**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

**PLEASE DO NOT DETACH**

THIS PAGE IS NOW PART OF THIS SURVEY