STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395566	A. BLDG: 00 B. WING:	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
HIGHLAND MANOR REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **340902**	**750 SCHOOLEY AVENUE EXETER, PA 18643**

(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 and State Licensure Survey completed on December 19, 2024, it was determined that the Highland Manor Rehabilitation and Nursing Center was in not compliance with the following requirements of 42 CFR Part 483 Subpart B Requirements for Long Term Care Facilities and the 28 PA Code Commonwealth of Pennsylvania Long Term Care Licensure Regulations.	F 0000		
F 0610 SS=D		F 0610		

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 0610 SS=D	Continued from page 1 483.12(c)(2)-(4) Investigate/Prevent/Correct Alleged Violation §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:	F 0610	Step I – Unable to retroactively address for Resident 23 Step 2 – Review of last 30 days of falls to assure there was no occurrence of injury noted few days later attributed to fall. DON or designee Step 3 – Education to nursing staff that occurrences of injury few days later require an investigation to assure injury was not related to something other than the fall. Staff educator or designee Step 4 - Random audits on incidents with injury noted days later to assure the investigations occur Weekly times 4 monthly times 2 - DON or designees Step 5 - Results of audits to QAPI Monthly times 2	Completion Date: **01/28/2025** Status: **APPROVED** Date: **12/30/2024**

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F 0610 SS=D	Continued from page 2 Based on a review of select facility policy, clinical records, information submitted by the facility, select investigative reports, and staff interviews, it was determined the facility failed to conduct a thorough investigation into an injury of unknown origin (a fractured humeral neck) for one resident out of 24 sampled (Resident 23). Findings include: A review of facility policy titled "Abuse Prevention Policy and Procedure," last reviewed by the facility on January 2, 2024, revealed it is the facility policy that an incident or suspected incident of resident abuse, mistreatment, neglect, or injury of unknown source is reported, then the administrator will assign the investigation to an appropriate individual. The policy indicates the information to be collected includes a review of all events leading up to the incident, a review of the resident's medical record to determine events leading up to the incident, and interviews with staff members on all shifts who have had contact with the resident at the time of the	F 0610		

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F 0610 SS=D	Continued from page 3 incident. The policy defines an injury of unknown source as the injury was not observed by any person or the source of the injury could not be explained by the resident, and the injury is suspicious because of the extent of the injury, location of the injury, number of injuries, or the pattern of injuries over time. A clinical record review revealed that Resident 23 was admitted to the facility on February 18, 2020, with diagnoses that included peripheral vascular disease (a circulatory condition that occurs when blood vessels outside the brain and heart narrow, spasm, or become blocked). A review of a quarterly Minimum Data Set assessment (MDS-a federally mandated standardized assessment process conducted periodically to plan resident care) dated April 2, 2024, revealed that Resident 23 is severely cognitively impaired with a BIMS score of 00 (Brief Interview for Mental Status- a tool within the	F 0610		

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F 0610 SS=D	Continued from page 4 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 00-07 indicates severe cognitive impairment). A progress note dated June 13, 2024, at 9:59 AM revealed Resident 23 rolled out of bed during care. During care, Employee 6, Nurse Aide (NA), reported the resident was rolled to her side to complete care and proceeded to fall out of bed. The resident landed on her knees on a fall mat with her torso remaining on the bed. New orders for X-rays to right femur and bilateral knees was obtained. The certified registered nurse practitioner was in to assess the resident and identified bruising to her lateral right femur. Resident 23 grimaced when bilateral knees were palpated. A witness statement dated June 13, 2024, provided by Employee 6, NA, revealed that while doing care, Resident 23's legs started going off the side of the bed. "I grabbed her shirt to stop her upper half from going, but she rolled off the bed onto her knees".	F 0610		

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F 0610 SS=D	Continued from page 5 A fall investigation report dated June 13, 2024, revealed Resident 23 was unable to give a description of the incident. A progress note dated June 13, 2024, revealed Employee 7, Certified Registered Nurse Practitioner (CRNP), assessed Resident 23 following the fall incident. The note indicated Resident 23 had evidence of pain and discomfort on palpitation of both knees and the right femur. Resident 23 stated, "I'm fine," during the assessment. Employee 7, CRNP, indicated Resident 23 jerks and moves legs during assessment and yelled out. The CRNP ordered an X-ray of bilateral knees and the right femur and Tylenol and morphine (an opioid analgesic medication) for as-needed pain An X-ray report dated June 13, 2024, at 1:53 PM, indicated multiple views of Resident 23's right femur, and routine views of bilateral knees revealed no fractures or acute findings.	F 0610		

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F 0610 SS=D	Continued from page 6 Physician's orders for Resident 23 to receive morphine sulfate (concentrate) oral solution 20 mg/ml with direction to give 0.25 ml by mouth every four hours as needed for pain was initiated on January 12, 2024 and was a current order as well as acetaminophen tablets of 325 mg with directions to give two tablets by mouth every four hours as needed for mild pain initiated on March 17, 2020. Physician's orders for Resident 23 to receive a pain screen every shift and medicate as needed with directions to check for pain each shift. A review of Resident 23's Medication Administration Record (MAR) from June 14, 2024, through June 17, 2024, revealed Resident 23 was assessed for pain each shift and had a pain level of 0 out of 10. A review of Resident 23's Medication Administration Record (MAR) from June 14, 2024, through June 17, 2024, revealed Resident 23 did not receive any as-needed pain medication during	F 0610		

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F 0610 SS=D	Continued from page 7 this date range. A progress note dated June 14, 2024, at 2:09 PM revealed Resident 23 with no injuries or complaints post fall from bed. A review of Resident 23's clinical record from June 14, 2024, through June 17, 2024, revealed no indication Resident 23 was experiencing pain. The first documented evidence indicating Resident 23 experienced shoulder pain was on June 18, 2024, five days after the resident fell. A progress note dated June 18, 2024, at 2:44 PM, revealed an X-ray report of Resident 23's right shoulder positive for right humeral fracture. The impressions indicate old fracture with a refracture. A new order is noted to consult with an orthopedic physician. Orders noted for the resident right upper extremity to be non-weight bearing, sling to right upper extremity, and hydrocodone (an opioid analgesic) straight for pain.	F 0610		

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F 0610 SS=D	Continued from page 8 A progress note dated June 18, 2024, revealed Employee 7, CRNP, assessed Resident 23 with reported increase in right shoulder pain. The note indicated Tylenol extra strength has been effective until recently and seems to not be working as per nursing staff. The resident is unable to answer questions correctly or verbalize the timeline of events correctly. Patient does wince and yell out with assessment of the right shoulder and humerus. An X-ray report dated June 18, 2024, indicated Resident 23 had a new linear lucency (a thin, dark line or transparent area on an X-ray that can indicate a foreign object or bone fracture) across the right humeral neck that is suspicious for fracture of an indeterminate age but appears non-united and potentially acute. The report indicated Resident 23 has a prior healed fracture of the right humeral neck, with reinjury and likely refracture on multiple views. A physician's order for hydrocodone-acetaminophen 5-325 mg with	F 0610		

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F 0610 SS=D	Continued from page 9 directions to give one tablet by mouth every eight hours for pain control initiated on June 19, 2024. A Medication Administration Record (MAR) dated June 2024 revealed Resident 23 received hydrocodone-acetaminophen 5-325 mg each shift from June 19, 2024, through June 30, 2024. A review of progress notes revealed Resident 23's representative declined further orthopedic consultation for the resident's humeral injury and agreed to the current plan of treatment. Further review of facility investigation reports and clinical records revealed no documented evidence the facility attempted to investigate the source of Resident 23's humeral fracture identified on June 18, 2024. During an interview on December 19, 2024, at approximately 9:00 AM, the Director of Nursing (DON) indicated the facility attributed Resident 23's humeral neck fracture identified on June 18, 2024,	F 0610		

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F 0610 SS=D	Continued from page 10 to the resident's fall on June 13, 2024. The DON was unable to provide any documented evidence indicating the facility reviewed and determined Resident 23's humeral neck fracture was a result of the fall on June 13, 2024. The DON confirmed that Resident 23 was not able to indicate how she sustained an injury. The DON confirmed that Resident 23 was assessed following the fall incident on June 13, 2024, by Employee 7, CRNP, and at the time of the assessment, no fractures or indicators of arm or shoulder pain were identified. Also, the DON confirmed the facility had no documented evidence indicating Resident 23 was experiencing pain from June 14, 2024, through June 17, 2024. The DON confirmed the first documented evidence that Resident 23 was experiencing increased shoulder pain was on June 18, 2024. The DON confirmed the facility failed to conduct a thorough investigation to attempt to identify how Resident 23 sustained a humeral neck fracture.	F 0610		

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F 0610 SS=D	Continued from page 11 28 Pa. Code 201.14 (c) Responsibility of licensee. 28 Pa. Code 201.18 (b)(1) Management. 28 Pa. Code 201.29 (a) Resident rights.	F 0610		
F 0656 SS=D		F 0656		

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F 0656 SS=D	Continued from page 12 483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future	F 0656	Step 1 – Mats were added to floor bilaterally when resident 104 was in bed. Step 2 – Review of current residents with falls in past 30 days to assure that fall mats on plan of care are in place for resident. DON or designee Step 3 – Education to nursing personnel on importance of implementation of fall preventatives to prevent injuries on residents with falls are in place as specified on care plans. Staff educator or designee Step 4 – Random audits for residents with fall risk to assure that care planned items are in place for resident. Weekly times 4 monthly times 2 Don or Designee Step 5 - Results to QAPI monthly times 2	Completion Date: **01/28/2025** Status: **APPROVED** Date: **12/30/2024**

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F 0656 SS=D	Continued from page 13 discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by:	F 0656		

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F 0656 SS=D	Continued from page 14 Based on observation, clinical record review, and staff interviews, it was determined the facility failed to implement a person-centered fall and injury prevention plan of care for one resident out of 24 sampled (Resident 104). Findings include: A clinical record review revealed Resident 104 was admitted to the facility on November 20, 2023, with diagnoses that included acute and chronic respiratory failure (a condition that occurs when the lungs can't exchange enough oxygen and carbon dioxide with the body, making it difficult to breathe). Further clinical record review revealed Resident 104 was at risk for falls and injury related to decreased mobility, medications, and history of falls with a care plan initiated on November 21, 2023. Interventions in place to protect Resident 104 from injury included bilateral fall mats on the sides of the bed initiated on December 13, 2024.	F 0656		

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F 0656 SS=D	Continued from page 15 A progress note dated December 13, 2024, at 4:15 AM revealed Resident 104 rolled out of his bed and was found on the floor. He was assessed and did not sustain any injury from the fall. An observation on December 17, 2024, at 9:30 AM in the resident's room revealed Resident 104 was in his bed. No mats were observed on either side of his bed. An observation on December 17, 2024, at 10:15 AM in the resident's room revealed Resident 104 was in his bed. No mats were observed on either side of his bed. At the time of the observation, Employee 5, Registered Nurse (RN), confirmed he has a current care plan intervention for bilateral floor mats. Employee 5, RN, confirmed the mats were not in place. During an interview on December 19, 2024, at approximately 9:30 AM, the Director of Nursing (DON) confirmed it is the facility's responsibility to ensure staff implement interventions developed on	F 0656		

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NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
HIGHLAND MANOR REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **340902**	**750 SCHOOLEY AVENUE EXETER, PA 18643**

(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 0656 SS=D	Continued from page 16 each resident's comprehensive person-centered care plan. The DON confirmed the facility failed to implement Resident 104's care plan to mitigate his risk of injury from falls, including implementation of bilateral mats in place when the resident is in bed. 28 Pa. Code 201.18(b)(1) Management. 28 Pa. Code 211.10(d) Resident care policies. 28 Pa. Code 211.12(d)(1)(5) Nursing services.	F 0656		
F 0684 SS=D		F 0684		

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F 0684 SS=D	Continued from page 17 483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 0684	Steo 1 – Unable to retroactively fix this issue for resident 15. Step 2 – Review of residents in facility to assure there are no other residents that are using incentive spirometry without orders. DON or designee Step 3 – Education to nursing staff on need for orders from MD and documentation requirements for resident who are to utilize special equipment. Staff Educator or Designee Step 4 – Random audits of resident requiring special equipment to assure MD orders and required documentation is in place. Weekly times 4 monthly times 2 – DON or Designee Step 5 – Results to QAPI Monthly times 2	Completion Date: **01/28/2025** Status: **APPROVED** Date: **12/30/2024**

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F 0684 SS=D	Continued from page 18 Based on observation, review of clinical records, and resident and staff interviews it was determined the facility failed to provide services consistent with professional standards of practice by failing to follow physician orders for a medical treatment that manages chronic lung conditions and promotes lung capacity and recovery for one resident (Resident 15) out of 24 sampled residents. Findings included: According to the Pennsylvania Code, Title 49, Professional and Vocational Standards, State Board of Nursing, 21.11 (a)(1)(2)(4) indicates that the registered nurse was to carry out nursing care actions that promote, maintain, and restore the well-being of individuals. 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	F 0684		

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F 0684 SS=D	Continued from page 19 judgement based on preparation, knowledge, skills, understandings and past experiences in nursing situations. The LPN participates in the planning, implementation, and evaluation of nursing care in settings where nursing takes place. 21.148 Standards of nursing conduct (a) A licensed practical nurse shall: (5) Document and maintain accurate records. According to the American Nurses Association Principles for Nursing Documentation, nurses document their work and outcomes and provide an integrated, real-time method of informing the health care team about the patient status. Timely documentation of the following types of information should be made and maintained in a patient's EHR (electronic health record) to support the ability of the health care team to ensure informed decisions and high-quality care in the continuity of patient care including Medication Records. A review of the clinical record revealed that Resident 15 was admitted to the facility on	F 0684		

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F 0684 SS=D	Continued from page 20 November 5, 2024, with diagnoses which included pneumothorax (a collapsed lung that occurs when air enters into the pleural cavity, the space around lungs and can cause pain in the chest and difficulty breathing), and post coronary artery bypass (a surgical procedure wherein a healthy artery or vein is grafted to bypass the blocked artery/vein). Further review of the clinical record revealed Resident 15 had a follow-up consultation with a cardiothoracic surgeon on November 18, 2024, with new physician's orders dated November 18, 2024, at 2:14 PM, for the resident to utilize an incentive spirometer (a medical device that exercises the lungs and is typically used after an illness, surgery or an injury to the chest or abdomen to prevent lung infections by expanding the lungs) every-two hours while awake (resident and/or family may utilize). A review of Resident 15's medication and treatment administration records dated November 18, 2024, through December 17, 2024, failed to reveal	F 0684		

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F 0684 SS=D	Continued from page 21 documented evidence that the physician's orders for incentive spirometry were implemented. Additionally, Resident 15's clinical record revealed a nurse's note completed by the Director of Nursing (DON) effective December 17, 2024, at 5:25 PM and initiated on December 18, 2024, at 8:27 AM, indicated the facility received a call from physician office (thoracic surgeon) that the resident's chest tube was not draining and the lung was not expanded - and reported this had been ongoing issue for this resident, even when he was in hospital, and was going to admit the resident to the hospital to see if anything else can be completed. During an interview with the DON on December 18, 2024, at 11:15 AM, confirmed the facility could not provide documented evidence that physician's orders for medical treatment, incentive spirometry, was implemented and completed as prescribed. 28 Pa. Code 211.12 (d)(1)(3)(5) Nursing services	F 0684		

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F 0684 SS=D	Continued from page 22 28 Pa. Code 211.5(f)(i)(ii)(iii) (viii)Medical records	F 0684		
F 0686 SS=D	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by:	F 0686	Step 1 – Unable to retroactively fix resident 26, wound has already resolved. Step 2 - Review of residents deemed high risk for pressure ulcers to assure documentation in place or added to documentation for preventatives. DON or Designee Step 3 – Education to nursing staff on completing and documenting preventative measures to prevention of pressure ulcers. Staff Educator or designee Step 4 – Random audits of residents at high risk to assure preventative documentation is in place. Weekly times 4 Monthly times 2 - DON or designee Step 5 Results reported to QAPI Monthly times 2	Completion Date: **01/28/2025** Status: **APPROVED** Date: **12/30/2024**

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F 0686 SS=D	Continued from page 23 Based on a review of clinical records, select facility policy, and staff interview, it was determined the facility failed to prevent the development of a pressure injury for one resident out of 24 sampled residents (Resident 26). Findings included: A clinical record review revealed Resident 26 was admitted to the facility on May 1, 2024, with diagnoses that included dementia (a syndrome characterized by a decline in cognitive function severe enough to interfere with daily life), muscle wasting (loss of muscle leading to its shrinking and weakening) and history of a left femoral neck fracture (a break in the upper part of the thigh bone). A review of the resident's person-centered plan of care, initiated on May 2, 2024, identified that Resident 26 was at risk for skin breakdown as evidence by impaired skin sensation, incontinence, and limited mobility with a resident goal to	F 0686		

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F 0686 SS=D	Continued from page 24 demonstrate no signs or symptoms of skin breakdown. Planned interventions included float heels while in bed, weekly skin assessments by a licensed nurse, and pressure redistribution mattress to the bed. A significant change Minimum Data Set (MDS - a federally mandated standardized assessment process conducted periodically to plan resident care) assessment was completed on June 6, 2024, due to the implementation of hospice service for comfort measures due to weakness and deteriorating medical status. Further review of a quarterly Minimum Data Set assessment dated July 31, 2024, revealed that Resident 26 had severe cognitive impairment with a BIMS score of 6 (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 0-7 indicates severe cognitive impairment). Additionally, this quarterly MDS indicated that	F 0686		

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F 0686 SS=D	Continued from page 25 Resident 26 required extensive assistance of two-plus persons physical assistance with bed mobility, transfers, and toilet use. A review of a facility provided incident investigation completed by Employee 1, RN/Nursing Unit Coordinator, dated September 4, 2024, at 7:50 AM, revealed during am care a hospice aide reported to her that Resident 26 had a DTI (deep tissue injury - The National Pressure Ulcer Advisory Panel defines a deep tissue injury as a pressure-related injury to subcutaneous tissues under intact skin and has the appearance of a deep bruise) on her right heel. The area was cleansed and elevated and the facility contracted wound healing specialists were notified. Physician and RP (responsible party) were notified. Further review of Resident 26's clinical record revealed a progress note completed by the contracted wound healing specialist's CRNP (certified registered nurse practitioner) dated September 4, 2024, at 5:28 PM, revealed that the	F 0686		

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F 0686 SS=D	Continued from page 26 resident was evaluated due to a newly developed DTI to her right heel and measured 2.2 cm by 2.4 cm by 0 cm with 100% intact maroon/brown epithelial tissue and fragile intact area surrounding the wound without exudate (bloody fluid). New recommendations were to keep heels floated at all times with pillows and cleanse with normal saline and apply skin prep to base of the wound twice per day. Further review of Resident 26's comprehensive person-centered plan of care failed to reveal that the facility revised pressure relieving interventions were developed and implemented to prevent the development of pressure injuries. Additionally, the facility could not provide documented evidence that preventative pressure injury tasks were consistently completed by staff. During an interview with the Director of Nursing (DON) on December 19, 2024, at 2:00 PM, confirmed that the facility failed to develop and implement interventions that prevented Resident 24	F 0686		

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F 0686 SS=D	Continued from page 27 from developing a facility acquired pressure area after a significant change in condition and implementation of hospice services. 28 Pa. Code 211.10(d) Resident care policies. 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services.	F 0686		
F 0697 SS=D		F 0697		

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F 0697 SS=D	Continued from page 28 483.25(k) Pain Management §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by:	F 0697	Step 1 – R-33 MAR was updated to include documentation of non-pharmacological interventions on 12/19/2024. Step 2 - Review of residents receiving prn pain medications to assure the "NPI" documentation in place. Step 3 - Education to licensed staff on the importance of offering and documenting non-pharmacological interventions prior to giving PRN pain medications. Step 4 – Random audits of residents receiving PRN pain medications to assure nonpharmacological interventions are in place and documentation completed. Weekly times 4 monthly times 2. DON or Designee Step 5 – Results to QAPI Monthly times 2	Completion Date: **01/28/2025** Status: **APPROVED** Date: **12/31/2024**

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F 0697 SS=D	Continued from page 29 Based on clinical record review and staff interview, it was determined that the facility failed to attempt non-pharmacological interventions to alleviate pain prior to the administration of a narcotic pain medication prescribed on an as needed basis for one resident (Resident 33) of 24 residents reviewed. Findings include: A review of the clinical record revealed that Resident 33 was admitted to the facility on November 20, 2024, with diagnoses to include low back pain and muscle weakness. A review of Resident 33's physician orders revealed the following orders: Tramadol 50mg (narcotic pain medication) give one tablet by mouth every six hours as needed (PRN) for pain initially dated November 20, 2024, and discontinued November 22, 2024. Oxycodone 5mg (narcotic pain medication) give one	F 0697		

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F 0697 SS=D	Continued from page 30 tablet by mouth every six hours as needed (PRN) for moderate to severe pain initially dated November 22, 2024, and discontinued November 29, 2024. Tramadol 50 mg give one tablet by mouth every 6 hours as needed for moderate to severe pain initially dated December 12, 2024, and remains as an active order. A review of the resident's November 2024 Medication Administration Record (MAR) revealed that staff administered the PRN Tramadol three times and the PRN Oxycodone eight times for the month of November. All doses of the pain medications were administered with no non-pharmacological interventions attempted prior to giving the pain medication. A review of the resident's December 2024 MAR revealed that staff administered the PRN Tramadol one time for the month of December. No non-pharmacological interventions were attempted	F 0697		

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F 0697 SS=D	Continued from page 31 prior to giving the pain medication. Interview with the Nursing Home Administrator and Director of Nursing on December 19, 2024, at approximately 2:00 PM confirmed that there was no evidence that non-pharmacological interventions were consistently attempted and proved ineffective prior to administration of the PRN pain medication. 28 Pa. Code 211.12(c)(d)(1)(5) Nursing Services	F 0697		
F 0756 SS=D		F 0756		

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HIGHLAND MANOR REHABILITATION AND NURSING CENTER STATE LICENSE NUMBER: **340902**	**750 SCHOOLEY AVENUE EXETER, PA 18643**

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F 0756 SS=D	Continued from page 32 483.45(c)(1)(2)(4)(5) Drug Regimen Review, Report Irregular, Act On §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.	F 0756	Step 1 – Medical Director reviewed the pharmacy recommendations and noted the rational and justification for continued use of Abilify and reason for rejection of the GDR. Step 2 – Going forward when CRNP reviews and gives responses to pharmacy recommendations they will be reviewed and signed off by Medical Director. Step 3 - Education to CRNP's and medical director for need of review and signing off of pharmacy recommendations. Step 4 - Audits will be completed going forward of pharmacy recommendations to assure medical director signs off in agreement prior to adding to resident's chart. Monthly times 3. DON or designee. Step 5 – Results to QAPI monthly times 2	Completion Date: **01/28/2025** Status: **APPROVED** Date: **12/31/2024**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395566	A. BLDG: __00_____ B. WING: _____	12/19/2024

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
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F 0756 SS=D	Continued from page 33 §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by:	F 0756		

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F 0756 SS=D	Continued from page 34 Based on a review of clinical records and staff interview, it was determined the attending physician failed to act upon pharmacist identified irregularities in the medication regimen of one of 24 residents sampled (Resident 1). Findings include: A review of the clinical record revealed Resident 1 was admitted to the facility on February 15, 2021, and had diagnoses which included major depressive disorder and schizophrenia (a mental health condition that is marked by symptoms such as hallucinations and delusions). A review of an October 2024 "Consultant Pharmacist Medication Regimen Review" revealed the consultant pharmacist indicated the resident's order for Abilify 10 MG (antipsychotic medication) was to be reviewed for a gradual dose reduction. Further review revealed the resident's attending physician failed to write an appropriate response to	F 0756		

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F 0756 SS=D	Continued from page 35 the pharmacy recommendation. Instead, the facility's consultant psychiatric CRNP (certified registered nurse practitioner) had responded to the pharmacy recommendation and signed off as she reviewed it. The resident's attending physician failed to document in the resident's clinical record the rational and justification for the continued use of Abilify and a reason for the rejection of the gradual dose reduction. An interview with the Director of Nursing (DON) on December 19, 2024, at approximately 2:00 PM confirmed that consultant psychiatric CRNP was responding to the pharmacy recommendations. Further the DON confirmed the attending physician failed to provide justification in the clinical record for the continued use of Resident 1's Abilify. 28 Pa. Code 211.9 (k) Pharmacy services.	F 0756		

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F 0756 SS=D	Continued from page 36 28 Pa. Code 211.12 (c)(d)(3) Nursing services.	F 0756		

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P 5280	Pharmacy services. (j.1) The facility shall have written policies and procedures for the disposition of medications that address all of the following: (1) Timely and safe identification and removal of medications for disposition. (2) Identification of storage methods for medications awaiting final disposition. (3) Control and accountability of medications awaiting final disposition consistent with standards of practice. (4) Documentation of actual disposition of medications to include the name of the individual disposing of the medication, the name of the resident, the name of the medication, the strength of the medication, the prescription number if applicable, the quantity of medication and the date of disposition. (5) A method of disposition to prevent diversion or accidental exposure consistent with applicable Federal and State requirements, local ordinances and standards of practice. This REGULATION is not met as evidenced by:	P 5280	Step I – Unable to retroactively address for closed chart for resident 121. Step 2- Unable to go back and fix for any discharged resident Step 3 - Education to licensed staff on disposition of medications for discharged and expired residents. Staff educator or designee. Step 4 Random review of discharged residents to assure disposition of medications is completed and documented at time of discharge. Weekly times 4 monthly times 2. DON or designee. Step 5 – Results to QAPI monthly times 2	Completion Date: **01/28/2025** Status: **APPROVED** Date: **12/30/2024**

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5280	Continued from page 1 Based on clinical record review and staff interview, it was determined the facility failed to document the accounting and disposition of residents' medications in the clinical record upon discharge of one of three sampled residents (Residents 121). Findings include: A review of the clinical record of Resident 121 revealed the resident was admitted to the facility on November 19, 2024, and expired and was discharged from the facility on November 21, 2024. There was no documented evidence in the resident's clinical record at the time of the survey ending December 19, 2024, of an accounting of the resident's remaining medications and the disposition of the medications upon the resident's discharge. An interview with the Nursing Home Administrator on December 19, 2024, at 2:00 PM confirmed the absence of documented accounting and disposition of medications upon discharge.	P 5280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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P 5280	Continued from page 2	P 5280		

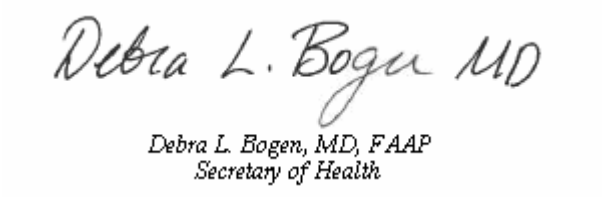
Certified End Page

HIGHLAND MANOR REHABILITATION AND NURSING CENTER

STATE LICENSE NUMBER: 340902

SURVEY EXIT DATE: 12/19/2024

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



Pennsylvania
Department of Health

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY