STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	395626	A. Building B. Wing	02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Penn Highlands Jefferson Manor	417 Route 28 Brookville, PA 15825

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on review of facility policy and clinical and facility records and staff interview, it was determined that the facility failed to ensure Resident R1 was free of neglect during care, which resulted in actual harm of a left hip fracture requiring surgical repair for one resident (Resident R1). Findings include: Review of a current facility policy entitled, Abuse-Neglect and Exploitation revealed the following Neglect: means failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness. Neglect occurs on an individual basis when a resident receives a lack of care in one or more areas (e.g. absence of frequent monitoring for a resident known to be incontinent, resulting in being left to lie in urine or feces, failure to apply safety alarms/devices, failure to follow the resident's plan of care, leaving a resident on the toilet for excessive amounts of time without returning to assist the resident, etc.). Neglect also occurs when a number of residents receive a lack of care in one or more regulatory groupings, a finding which reflects the facility's failure to have developed policies or implemented procedures to prohibit neglect. Resident R1's clinical record revealed an admission date of 1/8/24, with diagnoses that included dementia, anxiety, colon cancer, and osteoporosis. Review of a physician's order dated 10/15/25, directed that Resident R1 be assisted by two staff members while standing at a handrail. Review of physical therapy recommendation dated 10/23/25, directed that Resident R1 be assisted by two staff while standing at a hand rail for toileting. Review of Resident R1's potential for falls care plan initiated on 1/09/24, identified the resident as a transfer assist with 2 staff. Review of information submitted by the facility dated 1/9/26, revealed that Resident R1 was standing, holding onto a handrail bar, while a single staff member attempted to put on the resident's brief (incontinence product). During this time the resident fell to the floor injuring their left hip. Prior to this fall, resident safety interventions were to stand at a handrail with assistance of two staff members rather than one. A nurse's progress note dated 1/8/26, 11:37 a.m. documented that the nurse was alerted to assess Resident R1 in the main bathroom where Resident R1 was observed on the floor. The Nurse Aide (Employee E1) with the resident, stated that following a shower, the resident lost their balance and fell to the floor while being dried. The documenting nurse observed that one of the resident's legs appeared shorter than the other and that the resident complained of pain the nurse then called 911 to transfer the resident to the hospital. A nurse's note dated 1/8/26, at 5:16 p.m. documented that the during correspondence with the hospital it was determined that the Resident R1 had a broken hip and was being transferred to another hospital for further treatment. Review of an Employee Statement for Resident Incident/Accident form dated 1/8/26, revealed that NA Employee E1 documented that he/she showered Resident R1, stood the resident at a grab bar and while attempting to apply a brief, the resident's hand slipped from the bar and the resident fell to the floor. Review of a Witnessed Fall-SNF investigation form dated 1/8/26, revealed that NA Employee E1 disclosed that after showering Resident R1 he/she stood the resident at the shower room grab bar and while (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 0600 Level of Harm - Actual harm Residents Affected - Few	attempting to apply a brief the resident fell to the floor. During interview on 2/2/26, at 10:00 a.m., the Nursing Home Administrator (NHA) confirmed that Resident R1 required the assistance of two staff members while standing at a handrail rather than a single staff member and also confirmed that NA Employee E1 failed to obtain the assistance of another staff member while the resident was standing at a hand rail/grab bar which resulted in a fall with substantial harm of a hip fracture requiring surgical repair. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1)(e)(1) Management 28 Pa. Code 211.12(c) (d)(1)(3)(5) Nursing services

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on review of clinical records, facility documentation, and staff interviews, it was determined that the facility failed to ensure essential resident safety measures were followed to prevent a fall which resulted in the actual harm of a left hip fracture requiring surgical repair for one resident (Resident R1). Findings include: Resident R1's clinical record revealed an admission date of 1/8/24, with diagnoses that included dementia, anxiety, colon cancer and osteoporosis. Resident's R1's Minimum Data Set (MDS - periodic assessment of resident care needs), Section GG0170 Functional abilities Mobility dated 6/27/25, revealed Resident R1 was dependent (helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of two or more helpers is required for the resident to complete the activity) for transfers, changing position in bed and for toilet use. Review of a physician's order dated 10/15/25, directed that Resident R1 be assisted by two staff members while standing at a handrail. Review of physical therapy recommendation dated 10/23/25, directed that Resident R1 be assisted by two staff while standing at a hand rail for toileting. Review of information submitted by the facility dated 1/9/26, revealed that Resident R1 was standing, holding onto a handrail bar, while a single staff member attempted to put on the resident's brief (incontinence product). During this time the resident fell to the floor injuring their left hip. Prior to this fall, resident safety interventions were to stand at a handrail with assistance of two staff members rather than one. A nurse's progress note dated 1/8/26, 11:37 a.m. documented that the nurse was alerted to assess Resident R1 in the main bathroom where Resident R1 was observed on the floor. The Nurse Aide (Employee E1) with the resident, stated that following a shower, the resident lost their balance and fell to the floor while being dried. The documenting nurse observed that one of the resident's legs appeared shorter than the other and that the resident complained of pain the nurse then called 911 to transfer the resident to the hospital. A nurse's note dated 1/8/26, at 5:16 p.m. documented that the during correspondence with the hospital it was determined that the Resident R1 had a broken hip and was being transferred to another hospital for further treatment. Review of an Employee Statement for Resident Incident/Accident form dated 1/8/26, revealed that NA Employee E1 documented that he/she showered Resident R1, stood the resident at a grab bar and while attempting to apply a brief, the resident's hand slipped from the bar and the resident fell to the floor. Review of a Witnessed Fall-SNF investigation form dated 1/8/26, revealed that NA Employee E1 disclosed that after showering Resident R1 he/she stood the resident at the shower room grab bar and while attempting to apply a brief the resident fell to the floor. During interview on 2/2/26, at 10:00 a.m. the Nursing Home Administrator confirmed that Resident R1 required the assistance of two staff members while standing at a handrail rather than a single staff member and also confirmed that NA Employee E1 failed to obtain the assistance of another staff member while the resident was standing at a hand rail/grab bar which resulted in a fall with substantial harm of a hip fracture requiring surgical repair. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 201.18(b)(1)(e)(1) Management 28 Pa. Code 211.12(c)(d)(1)(3)(5) Nursing services