

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395626	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/09/2025
--	---	---	--

NAME OF PROVIDER OR SUPPLIER: PENN HIGHLANDS JEFFERSON MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE: 417 ROUTE 28 BROOKVILLE, PA 15825
STATE LICENSE NUMBER: 100802	

(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
F 0000	INITIAL COMMENT	F 0000		
F 0578 SS=D	Based on a Medicare/Medicaid Recertification, State Licensure, and Civil Rights Compliance Survey, and an Abbreviated Complaint Survey completed on January 9, 2025, it was determined that Penn Highlands Jefferson Manor was not in 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 0578		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395626	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/09/2025	
NAME OF PROVIDER OR SUPPLIER: PENN HIGHLANDS JEFFERSON MANOR STATE LICENSE NUMBER: 100802		STREET ADDRESS, CITY, STATE, ZIP CODE: 417 ROUTE 28 BROOKVILLE, PA 15825		
(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
F 0578 SS=D	Continued from page 1 483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance	F 0578	Nursing staff identified the proper code status with family for resident R13 to ensure the proper treatment plan is in process and updated. The Facility has educated staff on the policy of advanced directives along with accuracy. Facility has done an audit of all residents to determine appropriate code status is correct per resident's wishes and matches in the EMR along with the POLST. DON or designee will audit all new admissions for 6 weeks for accurate documentation of POLST vs order in the EMR. POLST will be reviewed with care plan meetings. We will review this as part of our Quality Assurance Performance Improvement meeting) (QAPI) and audit quarterly.	Completion Date: 03/10/2025 Status: APPROVED Date: 01/28/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395626	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/09/2025	
NAME OF PROVIDER OR SUPPLIER: PENN HIGHLANDS JEFFERSON MANOR STATE LICENSE NUMBER: 100802		STREET ADDRESS, CITY, STATE, ZIP CODE: 417 ROUTE 28 BROOKVILLE, PA 15825		
(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
F 0578 SS=D	Continued from page 2 directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by:	F 0578		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395626	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/09/2025
NAME OF PROVIDER OR SUPPLIER: PENN HIGHLANDS JEFFERSON MANOR STATE LICENSE NUMBER: 100802		STREET ADDRESS, CITY, STATE, ZIP CODE: 417 ROUTE 28 BROOKVILLE, PA 15825		
(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
F 0578 SS=D	Continued from page 3 Based on review of facility policy and clinical records, and staff interview, it was determined that the facility failed to ensure physician orders and resident Physician Order for Life Sustaining Treatment (POLST- a legal document specifying the resident/responsible party choices regarding life-sustaining treatments) were consistent for one of 22 residents reviewed (Resident R13). Findings include: The facility policy entitled "Advance Directives" dated 6/11/24, indicated that "The Director of Nursing Services (DNS) or designee notifies the attending physician of advance directives (or changes in advance directives) so that appropriate orders can be documented in the residents medical record and plan of care ...The plan of care for each resident is consistent with his or her documented treatment preferences and/or advance directive." Resident R13's clinical record revealed an admission date of 12/22/23, with diagnoses that included Type	F 0578		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395626	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/09/2025
NAME OF PROVIDER OR SUPPLIER: PENN HIGHLANDS JEFFERSON MANOR STATE LICENSE NUMBER: 100802		STREET ADDRESS, CITY, STATE, ZIP CODE: 417 ROUTE 28 BROOKVILLE, PA 15825		
(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
F 0578 SS=D	Continued from page 4 I diabetes (condition where the pancreas makes little or no insulin causing high blood sugar), hypertension (high blood pressure), and vitamin D deficiency. Resident R13's physician's orders dated 12/22/23, revealed an order for cardiopulmonary resuscitation (CPR-emergency life-saving procedure that is done when breathing or a heartbeat has stopped and when performed immediately can double or triple chances of survival after cardiac arrest). Resident R13's clinical record revealed a POLST dated 12/26/23, that identified Resident R13 requested Do Not Resuscitate-Allow Natural Death (DNR), Limited Additional Interventions. During an interview on 1/07/25, at 2:30 p.m. the Registered Nurse Supervisor Employee E2, confirmed Resident R13's physician's orders and POLST were not consistent with each other. 28 Pa. Code 201.18 (b)(1) Management	F 0578		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395626	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/09/2025
NAME OF PROVIDER OR SUPPLIER: PENN HIGHLANDS JEFFERSON MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE: 417 ROUTE 28 BROOKVILLE, PA 15825		
STATE LICENSE NUMBER: 100802				
(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
F 0578 SS=D	Continued from page 5 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 201.29(a) Resident rights 28 Pa. Code 211.5(f)(i) Medical records 28 Pa. Code 211.10(c) Resident care policies	F 0578		
F 0584 SS=D		F 0584		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395626	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/09/2025
NAME OF PROVIDER OR SUPPLIER: PENN HIGHLANDS JEFFERSON MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE: 417 ROUTE 28 BROOKVILLE, PA 15825		
STATE LICENSE NUMBER: 100802				
(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
F 0584 SS=D	Continued from page 6 483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all	F 0584	R1 and R70's wheelchairs were taken to wheelchair cleaning station and cleaned. Facility did whole-house review on all wheelchairs and cleanliness to determine other residents were not impacted. It was determined the facility failed to have a policy in place that addressed maintaining wheelchair cleanliness through the facility. All facility staff have been educated on the process needed to identify wheelchair cleanliness. Facility housekeeping department staff have been educated on the wheelchair cleaning schedule to ensure compliance. Housekeeping manager will monitor all chairs on given cycle to ensure they are being cleaned timely and as outlined in the policy. Housekeeping manager will review each chair on the cycle as they are to be cleaned weekly for 6 weeks and monthly there after All resident wheelchairs were taken to be cleaned. Education on a new policy to address the cleanliness of	Completion Date: 03/10/2025 Status: APPROVED Date: 01/31/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395626	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/09/2025
NAME OF PROVIDER OR SUPPLIER: PENN HIGHLANDS JEFFERSON MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE: 417 ROUTE 28 BROOKVILLE, PA 15825		
STATE LICENSE NUMBER: 100802				
(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
F 0584 SS=D	Continued from page 7 areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by:	F 0584	wheelchairs as part of a preventative measure has been created by the Nursing Home Administrator (NHA), Director of Nursing (DON) & housekeeping manager. The policy has been reviewed and staff educated. Facility has identified this as a performance improvement program for their Quality Assurance Performance Improvement (QAPI) Program. We will review quarterly with QAPI and track progress.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395626	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/09/2025	
NAME OF PROVIDER OR SUPPLIER: PENN HIGHLANDS JEFFERSON MANOR STATE LICENSE NUMBER: 100802		STREET ADDRESS, CITY, STATE, ZIP CODE: 417 ROUTE 28 BROOKVILLE, PA 15825		
(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
F 0584 SS=D	<p>Continued from page 8</p> <p>Based on observations and staff interview, it was determined that the facility failed to maintain a clean homelike environment for one of five units (Memory Lane).</p> <p>Findings include:</p> <p>Observation on Memory Lane on 1/06/25, at 3:00 p.m. revealed Resident R70 lying in bed with his/her eyes closed. Resident R70's wheelchair was at bedside and noted to have a dry, white, food-like substance on the seat cushion and on his/her bilateral arm rest.</p> <p>Observation on Memory Lane on 1/07/25, at 9:39 a.m. revealed Resident R1 lying in bed watching television. Resident R1's wheelchair was noted to be in the hallway and was observed to have a dried tan substance running down the left side of his/her seat cushion and the left side of his /her wheelchair base.</p> <p>Observation on Memory Lane on 1/07/25, at 1:00</p>	F 0584		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395626	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/09/2025
NAME OF PROVIDER OR SUPPLIER: PENN HIGHLANDS JEFFERSON MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE: 417 ROUTE 28 BROOKVILLE, PA 15825		
STATE LICENSE NUMBER: 100802				
(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
F 0584 SS=D	Continued from page 9 p.m. revealed Resident R70 sitting in his /her wheelchair in the resident lounge. Resident R70's wheelchair cushion was not visible at time of observation, but bilateral arm rest continued to have a dry white food-like substance present. Observation at this time, also revealed Resident R1 sitting in his/her wheelchair watching television with the dried tan substance still present on the left side of his/her seat cushion and the left side of his/her wheelchair base. During an interview on 1/07/25, at 1:00 p.m. Licensed Practical Nurse (LPN) Employee E1 confirmed that Residents R1 and R70's wheelchairs were unclean with dried debris noted. LPN Employee E1 stated the wheelchairs should not be dirty. 28 Pa. Code 201.18(b)(1) Management	F 0584		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395626	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/09/2025
NAME OF PROVIDER OR SUPPLIER: PENN HIGHLANDS JEFFERSON MANOR STATE LICENSE NUMBER: 100802		STREET ADDRESS, CITY, STATE, ZIP CODE: 417 ROUTE 28 BROOKVILLE, PA 15825		
(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
F 0625 SS=A	<p>483.15(d)(1)(2) Notice of Bed Hold Policy Before/Upon Trnsfr</p> <p>§483.15(d) Notice of bed-hold policy and return-</p> <p>§483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies-</p> <p>(i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;</p> <p>(ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;</p> <p>(iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and</p> <p>(iv) The information specified in paragraph (e)(1) of this section.</p> <p>§483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 0625	<p>I hereby acknowledge the CMS 2567-A, issued to PENN HIGHLANDS JEFFERSON MANOR for the survey ending 01/09/2025, AND attest that all deficiencies listed on the form will be corrected in a timely manner.</p>	<p>Completion Date: 03/10/2025 Status: APPROVED Date: 01/24/2025</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395626	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/09/2025	
NAME OF PROVIDER OR SUPPLIER: PENN HIGHLANDS JEFFERSON MANOR STATE LICENSE NUMBER: 100802		STREET ADDRESS, CITY, STATE, ZIP CODE: 417 ROUTE 28 BROOKVILLE, PA 15825		
(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
F 0625 SS=A	Continued from page 11 Based on review of facility policy and clinical records, and staff interview it was determined that the facility failed to provide the resident and/or resident representative with a written notice of the facility bed-hold policy (explanation of how long a bed can be held during a leave of absence and the cost per day) upon transfer for two of 22 residents reviewed (Residents R21 and R51). Findings include: Review of a facility policy entitled, "Bed-Holds and Returns" dated 6/11/24, revealed that at the time of transfer, written bed hold information would be given to the residents and the resident representatives. Resident R21's clinical record revealed an admission date of 8/28/20, with diagnoses that included high blood pressure, anxiety, depression and heart failure. A progress note dated 12/04/24, documented that Resident R21 was transferred to the hospital at around 8:10 a.m. There was no	F 0625		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395626	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/09/2025	
NAME OF PROVIDER OR SUPPLIER: PENN HIGHLANDS JEFFERSON MANOR STATE LICENSE NUMBER: 100802		STREET ADDRESS, CITY, STATE, ZIP CODE: 417 ROUTE 28 BROOKVILLE, PA 15825		
(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
F 0625 SS=A	Continued from page 12 evidence that Resident R21 and/or their representative were provided a copy of the facility bed-hold policy upon transfer from the facility. Resident R51's clinical record revealed an admission date of 5/2/23, with diagnoses that included chronic obstructive pulmonary disease (condition hen your lungs do not have adequate air flow), and peripheral vascular disease (a condition when there is restricted blood flow to the limb, usually legs). A progress note dated 10/18/24, documented that Resident R51 was transferred to the hospital at around 4:35 p.m. There was no evidence that Resident R51 and/or their representative were provided with a copy of the facility bed-hold policy upon transfer from the facility. During an interview on 1/08/25, at approximately 12:15 p.m. the Nursing Home Administrator confirmed that there was no evidence to indicate that Residents R21 and R51 and/or their representatives were provided with a copy of the facility bed-hold policy upon transfer.	F 0625		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395626	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____		(X3) DATE SURVEY COMPLETED: 01/09/2025
NAME OF PROVIDER OR SUPPLIER: PENN HIGHLANDS JEFFERSON MANOR STATE LICENSE NUMBER: 100802			STREET ADDRESS, CITY, STATE, ZIP CODE: 417 ROUTE 28 BROOKVILLE, PA 15825		
(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	
F 0625 SS=A	Continued from page 13 28 Pa. Code 201.18(e)(1) Management 28 Pa. Code 201.29(a) Resident rights	F 0625			
F 0641 SS=D		F 0641			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395626	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/09/2025
NAME OF PROVIDER OR SUPPLIER: PENN HIGHLANDS JEFFERSON MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE: 417 ROUTE 28 BROOKVILLE, PA 15825		
STATE LICENSE NUMBER: 100802				
(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
F 0641 SS=D	Continued from page 14 483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by:	F 0641	Residents R1 and R46 were reviewed, corrected and resubmitted for accuracy. The facility did a look back from 05/01/2024 to determine inaccurate coding in the MDS. All inaccurate MDS have been modified for accuracy and reviewed by the interdisciplinary team (IDT Team). IDT team has been educated on accurate MDS completion based on the RAI manual. Nursing home administrator, director of nursing or designee will audit 5 full MDS per week every week times 2 weeks and then 5 a month for the next 60 days thereafter. Facility will identify this as a focus area needing improvement and review at QAPI (Quality assurance Improvement Plan)	Completion Date: 03/10/2025 Status: APPROVED Date: 02/04/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395626	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/09/2025	
NAME OF PROVIDER OR SUPPLIER: PENN HIGHLANDS JEFFERSON MANOR STATE LICENSE NUMBER: 100802		STREET ADDRESS, CITY, STATE, ZIP CODE: 417 ROUTE 28 BROOKVILLE, PA 15825		
(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
F 0641 SS=D	Continued from page 15 Based on review of clinical records and staff interviews, it was determined that the facility failed to accurately code the Minimum Data Set (MDS - periodic assessment of resident care needs) for two of 22 residents reviewed (Residents R1 and R46). Findings include: Resident R1's clinical record revealed an admission date of 11/04/96, with diagnoses that included tracheostomy (a hole made through the front of the neck and into the windpipe [trachea] where a tube is placed to keep the hole open for breathing), gastrostomy tube (a surgical incision is made through the abdomen wall and into the stomach to insert a tube to provide feedings through when a person cannot take food or liquids by mouth), and spastic quadriplegic cerebral palsy (a severe form of cerebral palsy that affects all four limbs often times including the torso and face. Individuals experience muscle stiffness, uncontrolled muscle contractions, joint inflexibility and difficulty communicating).	F 0641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395626	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/09/2025	
NAME OF PROVIDER OR SUPPLIER: PENN HIGHLANDS JEFFERSON MANOR STATE LICENSE NUMBER: 100802		STREET ADDRESS, CITY, STATE, ZIP CODE: 417 ROUTE 28 BROOKVILLE, PA 15825		
(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
F 0641 SS=D	<p>Continued from page 16</p> <p>Resident R1's clinical record revealed a physician's order dated 5/20/24, indicating he/she receives Jevity 1.5 (a high calorie, fiber fortified liquid supplement for tube feedings) at 50 milliliters (ml) per hours continuously.</p> <p>An MDS with an Assessment Reference Date (ARD) of 11/11/24, under section Swallowing / Nutritional Status Section K0520 Nutritional Approaches indicated to check all of the following nutritional approaches that apply while a resident of the facility and within the last seven days. Section K0520B Feeding Tube (examples - nasogastric or abdominal [Peg]) was not checked for Resident R1 to identify they were receiving a feeding tube while a resident of the facility and within the last seven days.</p> <p>During an interview 1/09/25, at 9:34 a.m. the Director of Nursing confirmed that Resident R1's MDS with an ARD of 11/11/24, Section K0520B was coded inaccurately and should have been checked for having a feeding tube while a resident at the facility and within the last seven days.</p>	F 0641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395626	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/09/2025
NAME OF PROVIDER OR SUPPLIER: PENN HIGHLANDS JEFFERSON MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE: 417 ROUTE 28 BROOKVILLE, PA 15825		
STATE LICENSE NUMBER: 100802				
(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
F 0641 SS=D	Continued from page 17 Resident R46's clinical record revealed an admission date of 7/07/20, with diagnoses that included Alzheimer's Disease (brain disorder that slowly destroys memory, thinking skills, and, over time the ability to carry out the simplest tasks), and diabetes (a health condition that caused by the body's inability to produce enough insulin). Resident R46's clinical record revealed no evidence of weight loss or weight gain in the last month or six months. An MDS with an ARD of 7/12/24, under section Swallowing/Nutritional Status section K0300 Weight loss revealed for "loss of 5% in the last month or loss of 10% or more in last 6 months" was coded as "Yes, not on prescribed weight loss regimen." An MDS with an ARD of 9/10/24, under section Swallowing/Nutritional Status section K0300	F 0641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395626	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/09/2025	
NAME OF PROVIDER OR SUPPLIER: PENN HIGHLANDS JEFFERSON MANOR STATE LICENSE NUMBER: 100802		STREET ADDRESS, CITY, STATE, ZIP CODE: 417 ROUTE 28 BROOKVILLE, PA 15825		
(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
F 0641 SS=D	Continued from page 18 Weight loss revealed for "loss of 5% in the last month or loss of 10% or more in last 6 months" was coded as "Yes, not on prescribed weight loss regimen." An MDS with an ARD of 12/09/24, under section Swallowing/Nutritional Status section K0300 Weight loss revealed for "loss of 5% in the last month or loss of 10% or more in last 6 months" was coded as "Yes, not on prescribed weight loss regimen" and section K0310 Weight gain revealed for "gain of 5% in the last month or gain of 10% or more in last 6 months" was coded as "Yes, not on physician prescribed weight gain regimen." During an interview on 1/08/25, at 1:32 p.m. with Dietary Technician Employee E9, he/she verified that Resident R46 did not have a weight gain or loss. He/she also confirmed that Section K0300 of the MDS's dated 7/12/24, and 9/10/24, was incorrectly coded for Resident R46 regarding weight loss and Section's K0300 and K0310 of the MDS on 12/09/24, was incorrectly coded for Resident	F 0641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395626	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/09/2025
NAME OF PROVIDER OR SUPPLIER: PENN HIGHLANDS JEFFERSON MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE: 417 ROUTE 28 BROOKVILLE, PA 15825		
STATE LICENSE NUMBER: 100802				
(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
F 0641 SS=D	Continued from page 19 R46 regarding weight loss and gain. 28 Pa. Code 211.5(f)(iv)(ix) Medical records 28 Pa. Code 201.14 (a) Responsibility of Licensee	F 0641		
F 0684 SS=D		F 0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395626	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/09/2025
NAME OF PROVIDER OR SUPPLIER: PENN HIGHLANDS JEFFERSON MANOR STATE LICENSE NUMBER: 100802		STREET ADDRESS, CITY, STATE, ZIP CODE: 417 ROUTE 28 BROOKVILLE, PA 15825		
(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
F 0684 SS=D	Continued from page 20 483.25 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	R46 was turned and repositioned the concern was identified. Orders reviewed with physician and nursing supervisor to determine appropriate measures are in place and being followed. R56 pressure relieving device were applied per physician order. Orders were reviewed with care staff to ensure facility were in compliance with physician order. Facility has reviewed policy for pressure ulcer prevent & repositioning. Interdisciplinary team (IDT Team) met for policy revisions and updated to turning & repositioning, use of pressure reducing devices will be individualized based on patient's needs, RN assessment as well as Braden Scale. Facility education to all nursing staff regarding the policy change in turning and repositioning of residents and need for individualized plan to prevent skin breakdown including pressure reducing devices has been provided.	Completion Date: 03/10/2025 Status: APPROVED Date: 02/04/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395626	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/09/2025
NAME OF PROVIDER OR SUPPLIER: PENN HIGHLANDS JEFFERSON MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE: 417 ROUTE 28 BROOKVILLE, PA 15825		
STATE LICENSE NUMBER: 100802				
(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
F 0684 SS=D	Continued from page 21	F 0684	<p>Facility has reviewed care plans and orders of residents to determine who was at risk for skin breakdown and preventative measures put in place.</p> <p>Audits will be performed on all residents on individualized repositioning programs and with pressure reducing devices weekly for 8 weeks and monthly thereafter for 3 months. We will be auditing all residents on individualized care repositioning plans</p> <p>Facility has identified this as a performance improvement program for their Quality Assurance Performance Improvement (QAPI) Program. We will review quarterly with QAPI and track progress.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395626	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/09/2025	
NAME OF PROVIDER OR SUPPLIER: PENN HIGHLANDS JEFFERSON MANOR STATE LICENSE NUMBER: 100802		STREET ADDRESS, CITY, STATE, ZIP CODE: 417 ROUTE 28 BROOKVILLE, PA 15825		
(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
F 0684 SS=D	Continued from page 22 Based on review of clinical records, observations, and staff interviews, it was determined that the facility failed to ensure that physician's orders were followed for two of 22 residents reviewed (Residents R46 and R56). Findings include: Review of Resident R46's clinical record revealed an admission date of 7/7/20, with diagnoses that included Alzheimer's Disease (brain disorder that slowly destroys memory, thinking skills, and, over time the ability to carry out the simplest tasks), and diabetes (a health condition that caused by the body's inability to produce enough insulin). Review of Resident R46's physician's orders revealed an order dated 11/17/24, for staff to turn and reposition every two hours. Review of Resident R46's care plans revealed a care plan for impaired mobility with an intervention to turn and reposition every two hours.	F 0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395626	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/09/2025
NAME OF PROVIDER OR SUPPLIER: PENN HIGHLANDS JEFFERSON MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE: 417 ROUTE 28 BROOKVILLE, PA 15825		
STATE LICENSE NUMBER: 100802				
(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
F 0684 SS=D	Continued from page 23 Observations on 1/07/25, at 9:25 a.m., 11:20 a.m., 12:30 p.m., 12:50 p.m., 2:00 p.m., at 3:08 p.m., and at 3:15 p.m. all revealed Resident R46 was in his/her bed positioned on his/her buttocks. During an interview on 1/07/25, at 3:16 p.m. Licensed Practical Nurse (LPN) Employee E8 confirmed that Resident R46 has a physician's order to be turned and repositioned every two hours. He/she also confirmed that Resident R46 should be repositioned every two hours. Review of Resident R56's clinical record revealed an admission date of 12/27/23, with diagnoses that included Dementia (a disease that affects short term memory and the ability to think logically), and hypertension (high blood pressure). Review of Resident R56's physician's orders revealed an order dated 9/26/24, for pillow boots to bilateral feet at all times except care.	F 0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395626	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/09/2025
NAME OF PROVIDER OR SUPPLIER: PENN HIGHLANDS JEFFERSON MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE: 417 ROUTE 28 BROOKVILLE, PA 15825		
STATE LICENSE NUMBER: 100802				
(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
F 0684 SS=D	Continued from page 24 Review of Resident R56's care plans revealed a care plan for risk for skin breakdown with the intervention of pillow boots to bilateral feet at all times except care. Observations on 1/06/25, at 2:10 p.m. revealed Resident R56 was sitting in his/her wheelchair in the lounge with no pillow boots on bilateral feet and his/her pillow boots were lying on their bedside stand. Observations on 1/07/25, at 9:23 a.m., 10:10 a.m., and 11:20 a.m. all revealed Resident R56 was sitting in his/her wheelchair in the lounge with no pillow boots on bilateral feet and his/her pillow boots lying on their bed. Observations on 1/08/25, at 11:40 a.m. revealed Resident R56 was sitting in his/her wheelchair in the lounge with no pillow boots on bilateral feet and his/her pillow boots lying on their nightstand.	F 0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395626	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/09/2025
NAME OF PROVIDER OR SUPPLIER: PENN HIGHLANDS JEFFERSON MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE: 417 ROUTE 28 BROOKVILLE, PA 15825		
STATE LICENSE NUMBER: 100802				
(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
F 0684 SS=D	Continued from page 25 During an interview on 1/08/25, at 11:45 a.m. LPN Employee E10 confirmed that Resident R56 was sitting in the lounge with no pillow boots on his/her bilateral feet. He/she also confirmed that Resident R56's pillow boots should be on his/her bilateral feet per physician's orders. 28 Pa. Code 211.12(d)(3)(5) Nursing services	F 0684		
F 0695 SS=D		F 0695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395626	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/09/2025
NAME OF PROVIDER OR SUPPLIER: PENN HIGHLANDS JEFFERSON MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE: 417 ROUTE 28 BROOKVILLE, PA 15825		
STATE LICENSE NUMBER: 100802				
(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
F 0695 SS=D	Continued from page 26 483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by:	F 0695	R51 as well as R1 assistive breathing device was cleaned and replaced with new equipment including a nasal cannula. Orders were reviewed and appropriate Liter per minute setting was put in place. to match the physician order. Facility verified and addressed all residents were receiving oxygen per physician orders. All breathing apparatus were checked for cleanliness and cleaned per policy. Facility has educated nursing staff on the policy for cleaning breathing assisted devices and following physician orders. Director of Nursing or designee will audit 5 residents that receive oxygen therapy weekly for 6 weeks and once a month for 3 months to ensure the order matches what the resident is receiving with liters as well as cleanliness of the machines Facility has identified this as a performance improvement program for their Quality Assurance	Completion Date: 03/10/2025 Status: APPROVED Date: 02/06/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395626	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____		(X3) DATE SURVEY COMPLETED: 01/09/2025
NAME OF PROVIDER OR SUPPLIER: PENN HIGHLANDS JEFFERSON MANOR STATE LICENSE NUMBER: 100802			STREET ADDRESS, CITY, STATE, ZIP CODE: 417 ROUTE 28 BROOKVILLE, PA 15825		
(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	
F 0695 SS=D	Continued from page 27	F 0695	Performance Improvement (QAPI) Program. We will review quarterly with QAPI and track progress.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395626	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/09/2025	
NAME OF PROVIDER OR SUPPLIER: PENN HIGHLANDS JEFFERSON MANOR STATE LICENSE NUMBER: 100802		STREET ADDRESS, CITY, STATE, ZIP CODE: 417 ROUTE 28 BROOKVILLE, PA 15825		
(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
F 0695 SS=D	Continued from page 28 Based on review of facility policy and clinical records, observations, and staff interview, it was determined that the facility failed to provide oxygen according to physician's orders and failed to promote cleanliness and help prevent the spread of infection regarding respiratory care equipment for two of two residents reviewed for respiratory services (Residents R51 and R1). Findings include: A facility policy dated 6/11/24, entitled "Oxygen Administration" indicated "Verify that there is a physician's order for this procedure. Review the physician's order ... for oxygen administration." Resident R51's clinical record revealed an admission date of 5/02/23, with diagnoses that included chronic obstructive pulmonary disease (COPD - condition when your lungs do not have adequate air flow), and peripheral vascular disease (PVD - a condition when there is restricted blood flow to the limb, usually legs).	F 0695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395626	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/09/2025	
NAME OF PROVIDER OR SUPPLIER: PENN HIGHLANDS JEFFERSON MANOR STATE LICENSE NUMBER: 100802		STREET ADDRESS, CITY, STATE, ZIP CODE: 417 ROUTE 28 BROOKVILLE, PA 15825		
(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
F 0695 SS=D	<p>Continued from page 29</p> <p>Resident R51's Care Plan revealed a care plan for altered cardiac output and respiratory function with an intervention of oxygen at 3 lpm (liters per minute) via nasal cannula (a thin tube with two prongs that fit into the resident's nostrils to deliver oxygen), Licensed Nurse to ensure oxygen is in place, and being administered at ordered rate.</p> <p>Resident R51's clinical record revealed a physician's order dated 10/27/24, for oxygen at 3 lpm via nasal cannula for hypoxia (low oxygen levels). Further review revealed a physician's order to clean oxygen concentrator filter with hot soapy water weekly on Saturday.</p> <p>Observation on 1/07/25, at 9:50 a.m. revealed Resident R51 lying on his/her bed with supplemental oxygen in place and the oxygen concentrator liter flow set at 4 lpm. Further observation of the concentrator filters to bilateral sides of the oxygen concentrator revealed a large amount of a gray fluffy substance covering bilateral filters.</p>	F 0695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395626	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/09/2025
NAME OF PROVIDER OR SUPPLIER: PENN HIGHLANDS JEFFERSON MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE: 417 ROUTE 28 BROOKVILLE, PA 15825		
STATE LICENSE NUMBER: 100802				
(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
F 0695 SS=D	Continued from page 30 During an interview on 1/07/25, at 10:10 a.m. Licensed Practical Nurse (LPN) Employee E8 confirmed that Resident R51's oxygen concentrator was on and set at 4 lpm and was not in accordance with the physician's order dated 10/27/24, for oxygen at 3 lpm. LPN Employee E1 also confirmed that the filters to the bilateral sides of the oxygen concentrator were covered in a gray fluffy substance and the filters should be clean per physician orders. Resident R1's clinical record revealed an admission date of 11/04/96, with diagnoses that included tracheostomy (a hole made through the front of the neck and into the windpipe [trachea] where a tube is placed to keep the hole open for breathing), gastrostomy tube (a surgical incision is made through the abdomen wall and into the stomach to insert a tube to provide feedings through when a person cannot take food or liquids by mouth), and spastic quadriplegic cerebral palsy (a severe form of cerebral palsy that affects all four limbs often times	F 0695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395626	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/09/2025	
NAME OF PROVIDER OR SUPPLIER: PENN HIGHLANDS JEFFERSON MANOR STATE LICENSE NUMBER: 100802		STREET ADDRESS, CITY, STATE, ZIP CODE: 417 ROUTE 28 BROOKVILLE, PA 15825		
(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
F 0695 SS=D	<p>Continued from page 31</p> <p>including the torso and face. Individuals experience muscle stiffness, uncontrolled muscle contractions, joint inflexibility and difficulty communicating).</p> <p>Resident R1's clinical record revealed a physician's order dated 5/20/24, for oxygen at 4 lpm via trach mask (mask that covers the tracheostomy site to administer oxygen). Further review of physician's orders revealed an order dated 5/20/24, to clean oxygen concentrator filter with hot soapy water weekly with tubing change on 11-7 shift weekly on Saturday.</p> <p>Observations on 1/06/25, at 12:53 p.m. and 1:55 p.m. revealed Resident R1's oxygen concentrator had a filter on the back of the concentrator that contained a gray dusty substance.</p> <p>During an interview on 1/06/25, at 1:55 p.m. Registered Nurse Employee E2 confirmed that the oxygen concentrator filter contained a gray dusty substance and should not, but was unsure as to how often or when they are to be cleaned.</p>	F 0695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395626	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/09/2025
--	---	---	--

NAME OF PROVIDER OR SUPPLIER: PENN HIGHLANDS JEFFERSON MANOR STATE LICENSE NUMBER: 100802	STREET ADDRESS, CITY, STATE, ZIP CODE: 417 ROUTE 28 BROOKVILLE, PA 15825
---	--

(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
F 0695 SS=D	Continued from page 32 28 Pa. Code 211.10(c) Resident care policies 28 Pa. Code 211.12(d)(1)(5) Nursing services	F 0695		
F 0761 SS=D		F 0761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395626	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/09/2025
NAME OF PROVIDER OR SUPPLIER: PENN HIGHLANDS JEFFERSON MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE: 417 ROUTE 28 BROOKVILLE, PA 15825		
STATE LICENSE NUMBER: 100802				
(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
F 0761 SS=D	Continued from page 33 483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:	F 0761	Facility has done a full sweep to identify if any other residents have been impacted by the concern. No other residents were impacted. All other medication carts in the facility were reviewed by director of nursing or RN supervisor to determine no other inappropriate labeling or lack there of had occurred. Inter-disciplinary team (IDT) reviewed the patient's care plan as well as physician orders with resident. Resident R22 understands there is a safety risk for other residents for leaving meds unattended in the room and is agreeable to keeping medications secured in the medication cart outside of medication administration times. Resident requests at the time of the medication needing given that medications be brought to bed-side, then R22 will prepare medications and take them supervised with nurse. The medications will be locked again and secured in med cart. R22 expresses the safety factor and is willing to participate.	Completion Date: 03/10/2025 Status: APPROVED Date: 02/04/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395626	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/09/2025
NAME OF PROVIDER OR SUPPLIER: PENN HIGHLANDS JEFFERSON MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE: 417 ROUTE 28 BROOKVILLE, PA 15825		
STATE LICENSE NUMBER: 100802				
(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
F 0761 SS=D	Continued from page 34	F 0761	<p>Nursing Staff have been educated on the new process in regard to this resident. Care plan and orders have been updated.</p> <p>Education was also provided to nursing staff on labeling vials.</p> <p>DON or designee will audit that this new process is happening 3 times a week for 4 weeks and then weekly for 6 weeks. Audits will be completed on multi-dose labeling and audited 3 times weekly for 6 weeks and once weekly for one month.</p> <p>Facility has identified this as a performance improvement program for their Quality Assurance Performance Improvement (QAPI) Program. We will review quarterly with QAPI and track progress.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395626	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/09/2025	
NAME OF PROVIDER OR SUPPLIER: PENN HIGHLANDS JEFFERSON MANOR STATE LICENSE NUMBER: 100802		STREET ADDRESS, CITY, STATE, ZIP CODE: 417 ROUTE 28 BROOKVILLE, PA 15825		
(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
F 0761 SS=D	Continued from page 35 Based on review of facility policies, observations, and staff interviews, it was determined that the facility failed to label a multi-dose insulin (medication to treat elevated blood sugar levels) vial with the date it was opened, in one of five medication carts (Memory Lane) and failed to ensure medications for self-administration were properly secured for one of 22 residents reviewed (Resident R22). Findings include: Review of the facility policy entitled "Vials and Ampules of Injectable Medications" dated 6/11/24, indicated vials and ampules medications are used in accordance with the manufacturer's recommendations or the providers pharmacy's directions for storage, use, and disposal. It also indicated that at a minimum, the date opened must be recorded. Review of the facility policy entitled "Self-Administration of Medications" dated 6/11/24, indicated self-administered medications are stored in	F 0761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395626	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/09/2025	
NAME OF PROVIDER OR SUPPLIER: PENN HIGHLANDS JEFFERSON MANOR STATE LICENSE NUMBER: 100802		STREET ADDRESS, CITY, STATE, ZIP CODE: 417 ROUTE 28 BROOKVILLE, PA 15825		
(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
F 0761 SS=D	<p>Continued from page 36</p> <p>a safe and secure place, which is not accessible by other residents. If safe storage is not possible in the resident's room, the medications of the residents permitted to self-administer are stored on a central medication cart or in the medication room. A licensed nurse transfers the unopened medication to the resident when the resident requests them.</p> <p>Observation on 1/07/25, at 8:30 a.m. revealed the Memory Lane medication cart contained an opened undated multi-dose Lantus insulin vial and the manufacturer's packaging was labeled to discard within 28 days of opening.</p> <p>During an interview at that time, Licensed Practical Nurse (LPN) Employee E1 confirmed that multi-dose vials/containers of medication are to be dated upon opening to ensure that staff discard them in a timely manner and the medication is not to be utilized past the medication expiration.</p> <p>Resident R22's clinical record revealed an admission date of 6/16/16, with diagnoses that included</p>	F 0761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395626	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/09/2025	
NAME OF PROVIDER OR SUPPLIER: PENN HIGHLANDS JEFFERSON MANOR STATE LICENSE NUMBER: 100802		STREET ADDRESS, CITY, STATE, ZIP CODE: 417 ROUTE 28 BROOKVILLE, PA 15825		
(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
F 0761 SS=D	<p>Continued from page 37</p> <p>diverticulitis (an inflammation or infection in the digestive tract), type II diabetes (condition where the pancreas does not make enough insulin), and hypothyroidism (condition where the thyroid gland does not produce enough thyroid hormone).</p> <p>Resident R22's physician's orders dated 3/04/24, revealed an order indicating Resident R22 may self-administer medications. Medications must be returned to nurse in between administration times for safe keeping.</p> <p>Observation of Resident R22's room on 1/07/25, at approximately 10:00 a.m. revealed a plastic storage bin filled with multiple medications sitting on the resident's bedside tray table. At that time, Resident R22 stated he/she self-administers his/her medications and that the medications remain on his/her bedside tray table all day.</p> <p>During an interview on 1/07/25, at approximately 10:12 a.m. LPN Employee E6 confirmed that Resident R22's medications are given to him/her in a</p>	F 0761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395626	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/09/2025	
NAME OF PROVIDER OR SUPPLIER: PENN HIGHLANDS JEFFERSON MANOR STATE LICENSE NUMBER: 100802		STREET ADDRESS, CITY, STATE, ZIP CODE: 417 ROUTE 28 BROOKVILLE, PA 15825		
(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
F 0761 SS=D	Continued from page 38 plastic storage bin and are left in Resident R22's room throughout the day, unsecured. During an interview on 1/08/25, at approximately 9:00 a.m. LPN Employee E7 confirmed that he/she would take Resident R22's medications to his/her room in the morning and the medications would remain unsecured in Resident R22's room until approximately 5:00 p.m. 28 Pa. Code 201.18(b)(1) Management 28 Pa. Code 211.9(a)(1) Pharmacy services 28 Pa. Code 211.12(d)(1)(3)(5) Nursing services	F 0761		
F 0842 SS=D		F 0842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395626	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/09/2025	
NAME OF PROVIDER OR SUPPLIER: PENN HIGHLANDS JEFFERSON MANOR STATE LICENSE NUMBER: 100802		STREET ADDRESS, CITY, STATE, ZIP CODE: 417 ROUTE 28 BROOKVILLE, PA 15825		
(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
F 0842 SS=D	Continued from page 39 483.20(f)(5), 483.70(h)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;	F 0842	Facility has reviewed all other residents and determined no others were affected. Education has been provided on policy for enteral feeds and flushes with all licensed nursing staff to ensure care plans and physician orders are being followed and recorded accurately. Documentation of med administration policy has been educated and reviewed with all nursing staff. Director of Nursing or designee will audit 5 charts for errors in antibiotics as well as flushes and feeds being documented appropriately daily for 2 weeks and 3 times weekly for 6 weeks. R1 care-plan was reviewed along with current status; it was determined R1 did not receive any adverse effects. Residents' weight is maintained with no evidence of dehydration. R37 also did not have adverse effects because the antibiotic was completed in the 7 day	Completion Date: 03/10/2025 Status: APPROVED Date: 02/04/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395626	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/09/2025	
NAME OF PROVIDER OR SUPPLIER: PENN HIGHLANDS JEFFERSON MANOR STATE LICENSE NUMBER: 100802		STREET ADDRESS, CITY, STATE, ZIP CODE: 417 ROUTE 28 BROOKVILLE, PA 15825		
(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
F 0842 SS=D	Continued from page 40 (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.	F 0842	course. Facility has identified this as a performance improvement program for their Quality Assurance Performance Improvement (QAPI) Program. We will review quarterly with QAPI and track progress.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395626	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/09/2025
--	---	---	--

NAME OF PROVIDER OR SUPPLIER: PENN HIGHLANDS JEFFERSON MANOR STATE LICENSE NUMBER: 100802	STREET ADDRESS, CITY, STATE, ZIP CODE: 417 ROUTE 28 BROOKVILLE, PA 15825
---	--

(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
F 0842 SS=D	Continued from page 41 This REQUIREMENT is not met as evidenced by:	F 0842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395626	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/09/2025
NAME OF PROVIDER OR SUPPLIER: PENN HIGHLANDS JEFFERSON MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE: 417 ROUTE 28 BROOKVILLE, PA 15825		
STATE LICENSE NUMBER: 100802				
(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
F 0842 SS=D	Continued from page 42 Based on review of facility policy and clinical records, and staff interview, it was determined that the facility failed to maintain complete and accurate documentation for two of 22 residents reviewed (Residents R1 and R37). Findings include: Facility policy entitled "Documentation" dated 6/11/24, indicated to document information as soon as possible to ensure accuracy of the information and to reflect ongoing care and to document only care, treatment, and medication that have actually been provided or administered. Facility policy entitled "Enteral Tube Feeding Via Continuous Pump" dated 6/11/24, indicated the person performing the procedure should record the amount and type of enteral feeding and the average fluid intake per day. Resident R1's clinical record revealed an admission date of 11/04/96, with diagnoses that included	F 0842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395626	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/09/2025	
NAME OF PROVIDER OR SUPPLIER: PENN HIGHLANDS JEFFERSON MANOR STATE LICENSE NUMBER: 100802		STREET ADDRESS, CITY, STATE, ZIP CODE: 417 ROUTE 28 BROOKVILLE, PA 15825		
(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
F 0842 SS=D	Continued from page 43 tracheostomy (a hole made through the front of the neck and into the windpipe [trachea] where a tube is placed to keep the hole open for breathing), gastrostomy tube (a surgical incision is made through the abdomen wall and into the stomach to insert a tube to provide feedings through when a person cannot take food or liquids by mouth), and spastic quadriplegic cerebral palsy (a severe form of cerebral palsy that affects all four limbs often times including the torso and face. Individuals experience muscle stiffness, uncontrolled muscle contractions, joint inflexibility and difficulty communicating). Resident R1's clinical record revealed a physician's order dated 5/24/24, for flush enteral feeding tube with 150 milliliter (ml) of water every four hours (300 ml of water per shift plus more depending on medication administration) and with 50 ml of water before and after medication administration; a physician's order dated 5/20/24, for Jevity 1.5 (a high calorie, fiber fortified liquid supplement for tube feedings) at 50 ml per hour continuous via gastric tube (a total of 400 ml per shift and 1200 ml total of	F 0842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395626	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/09/2025	
NAME OF PROVIDER OR SUPPLIER: PENN HIGHLANDS JEFFERSON MANOR STATE LICENSE NUMBER: 100802		STREET ADDRESS, CITY, STATE, ZIP CODE: 417 ROUTE 28 BROOKVILLE, PA 15825		
(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
F 0842 SS=D	Continued from page 44 formula in a twenty-four hour period); and a physician's order dated 5/20/24, to document the amount of formula and water provided every eight hours - total intake every twenty-four hours. Review of documentation of water flushes for Resident R1 from 12/10/24, through 1/07/25, under staff tasks revealed Resident R1 received less than the ordered 300 ml of water flush per shift (not counting medication flushes) one time on day shift, one time on evening shift, and three times on overnight shift. Documentation also revealed that facility lacked any evidence of water flushes one time on day shift, eight times on evening shift, and three times on overnight shift. Review of documentation of formula intake for Resident R1 from 12/10/24, through 1/07/25, under staff tasks revealed Resident R1 received less than the ordered 400 ml of formula per shift four times on day shift, ten times on evening shift, and eleven times on overnight shift; and Resident R1 received more than the ordered 400 ml of formula per shift eleven	F 0842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395626	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/09/2025	
NAME OF PROVIDER OR SUPPLIER: PENN HIGHLANDS JEFFERSON MANOR STATE LICENSE NUMBER: 100802		STREET ADDRESS, CITY, STATE, ZIP CODE: 417 ROUTE 28 BROOKVILLE, PA 15825		
(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
F 0842 SS=D	<p>Continued from page 45</p> <p>times on day shift, seven times on evening shift, and eleven times on overnight shift. Documentation also revealed that facility lacked any evidence of formula being provided one time on day shift, seven times on evening shift, and three times on overnight shift.</p> <p>During an interview on 1/08/25, at 2:49 p.m. the Director of Nursing confirmed that Resident R1's clinical record contained incomplete and inaccurate documentation related to his / her tube feeding formula and water flushes.</p> <p>Resident R37's clinical record revealed an admission date of 5/30/24, with diagnoses that included diabetes (a health condition caused by the body's inability to produce enough insulin), high blood pressure, and urinary tract infection (UTI).</p> <p>Resident R37's clinical record revealed a physician's order dated 12/05/24, for Keflex (antibiotic) 500 milligrams by mouth every twelve hours for UTI for seven days. Review of the Medication</p>	F 0842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395626	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/09/2025	
NAME OF PROVIDER OR SUPPLIER: PENN HIGHLANDS JEFFERSON MANOR STATE LICENSE NUMBER: 100802		STREET ADDRESS, CITY, STATE, ZIP CODE: 417 ROUTE 28 BROOKVILLE, PA 15825		
(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
F 0842 SS=D	<p>Continued from page 46</p> <p>Administration Record (MAR) revealed the first dose was administered at 9:00 a.m. on 12/15/24, and the last dose was administered at 9:00 p.m. on 12/21/24.</p> <p>Resident R37's clinical record progress notes dated / timed for 12/21/24, at 10:22 p.m., 12/21/24 at 11:36 p.m., 12/22/24, at 2:25 p.m., 12/22/24, at 8:56 p.m., 12/23/24, at 11:38 a.m., 12/23/24, at 6:54 p.m., 12/24/24, at 5:11 a.m., 12/24/24, at 10:43 a.m., 12/24/24, at 11:09 p.m., 12/25/2024, at 12:10 a.m., 12/25/24, at 9:54 p.m., 12/25/23, at 11:07 p.m., 12/26/24, at 11:02 a.m., and 12/26/24, at 6:49 p.m. indicated Resident R37 was receiving Keflex for a UTI when the last dose was received at 9:00 p.m. on 12/21/24.</p> <p>During an interview on 1/08/25, at 12:23 p.m. the Director of Nursing confirmed that Resident R37's clinical record contained inaccurate documentation related to him/her receiving Keflex for a UTI.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p>	F 0842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395626	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/09/2025
NAME OF PROVIDER OR SUPPLIER: PENN HIGHLANDS JEFFERSON MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE: 417 ROUTE 28 BROOKVILLE, PA 15825		
STATE LICENSE NUMBER: 100802				
(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
F 0842 SS=D	Continued from page 47 28 Pa. Code 211.12(d)(1)(2)(5) Nursing services	F 0842		
F 0880 SS=D		F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395626	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/09/2025	
NAME OF PROVIDER OR SUPPLIER: PENN HIGHLANDS JEFFERSON MANOR STATE LICENSE NUMBER: 100802		STREET ADDRESS, CITY, STATE, ZIP CODE: 417 ROUTE 28 BROOKVILLE, PA 15825		
(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
F 0880 SS=D	Continued from page 48 483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;	F 0880	Nursing Home Administrator (NHA), Director of Nursing (DON) & infection preventionist reviewed education & procedure again individually with the staff member that failed to follow policies & procedures related to Enhanced Barrier Precautions (EBP). Facility reviewed all resident under EBP and found none to be at risk. Part of our review determined all residents on EBP do have the proper PPE available. NHA & DON re-educated on EBP and how it impacts them in their roles and to follow care plan for EBP. R1 CarePlan reviewed and educated staff member individually on following policy for EBP with R1 specifically as well as all other residents under the same precautions. Director of Nursing or designee will audit proper use of EBP when providing care to 3 residents under	Completion Date: 03/10/2025 Status: APPROVED Date: 01/31/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395626	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/09/2025	
NAME OF PROVIDER OR SUPPLIER: PENN HIGHLANDS JEFFERSON MANOR STATE LICENSE NUMBER: 100802		STREET ADDRESS, CITY, STATE, ZIP CODE: 417 ROUTE 28 BROOKVILLE, PA 15825		
(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
F 0880 SS=D	Continued from page 49 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:	F 0880	precautions every shift time two weeks. and then 5 residents monthly for 3 months. Staff have been educated and are aware how and when to utilized PPE for EBP residents. This process will be reviewed in our QAPI (Quality Assurance Performance Improvement) plan and updated as needed based on ongoing audits.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395626	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/09/2025
--	---	---	--

NAME OF PROVIDER OR SUPPLIER: PENN HIGHLANDS JEFFERSON MANOR STATE LICENSE NUMBER: 100802	STREET ADDRESS, CITY, STATE, ZIP CODE: 417 ROUTE 28 BROOKVILLE, PA 15825
---	--

(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
F 0880 SS=D	Continued from page 50	F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395626	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/09/2025	
NAME OF PROVIDER OR SUPPLIER: PENN HIGHLANDS JEFFERSON MANOR STATE LICENSE NUMBER: 100802		STREET ADDRESS, CITY, STATE, ZIP CODE: 417 ROUTE 28 BROOKVILLE, PA 15825		
(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
F 0880 SS=D	Continued from page 51 Based on review of facility policy and clinical records, observation, and staff interview, it was determined that the facility failed to follow acceptable infection control practices regarding enhanced barrier precautions (EBP) during observation of tracheostomy (a hole made through the front of the neck and into the windpipe [trachea] where a tube is placed to keep the hole open for breathing) care for one of three residents observed for care requiring EBP (Resident R1). Findings include: A facility policy entitled "Enhanced Barrier Precautions" dated 6/11/24, indicated that Enhanced Barrier Precautions (EBP) are utilized to prevent the spread of multi-drug resistant organisms to residents. The policy further stated that high contact resident care activities that require the use of gown and gloves for EBP's included devise care or use such as tracheostomies and that face protection may be used if there is also a risk of splash or spray.	F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395626	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/09/2025	
NAME OF PROVIDER OR SUPPLIER: PENN HIGHLANDS JEFFERSON MANOR STATE LICENSE NUMBER: 100802		STREET ADDRESS, CITY, STATE, ZIP CODE: 417 ROUTE 28 BROOKVILLE, PA 15825		
(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
F 0880 SS=D	<p>Continued from page 52</p> <p>Resident R1's clinical record revealed an admission date of 11/04/96, with diagnoses that included tracheostomy (a hole made through the front of the neck and into the windpipe [trachea] where a tube is placed to keep the hole open for breathing), gastrostomy tube (a surgical incision is made through the abdomen wall and into the stomach to insert a tube to provide feedings through when a person cannot take food or liquids by mouth), and spastic quadriplegic cerebral palsy (a severe form of cerebral palsy that affects all four limbs often times including the torso and face. Individuals experience muscle stiffness, uncontrolled muscle contractions, joint inflexibility and difficulty communicating).</p> <p>Resident R1's clinical record revealed a physician's order dated 10/24/24, that identified for the use of Enhanced Barrier Precautions for Tracheostomy.</p> <p>Observation of tracheostomy care on 1/06/25, at 1:50 p.m. revealed signage on Resident R1's door identifying EBP. Personal protective equipment (PPE) was readily available outside Resident R1's</p>	F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395626	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/09/2025
NAME OF PROVIDER OR SUPPLIER: PENN HIGHLANDS JEFFERSON MANOR STATE LICENSE NUMBER: 100802		STREET ADDRESS, CITY, STATE, ZIP CODE: 417 ROUTE 28 BROOKVILLE, PA 15825		
(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
F 0880 SS=D	Continued from page 53 door including goggles, surgical mask, gloves, and gowns. Registered Nurse (RN) Employee E2 had a surgical mask on, but pulled down below his/her nose, and gloves, and failed to DON (put on) required proper personal protective equipment (PPE) by not wearing a gown during tracheostomy care for Resident R1. During an interview on 1/06/25, at 1:56 p.m. RN Employee E2 confirmed he/she did not wear a gown as required stating that if the resident does not have an infection or COVID, he/she does not wear a gown and the additional PPE was not needed if the resident was well. 28 Pa. Code 211.10(c) Resident care policies 28 Pa. Code 211.12(d)(1)(5) Nursing services	F 0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395626	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u> 00 </u> B. WING: <u> </u>	(X3) DATE SURVEY COMPLETED: 01/09/2025
--	---	---	--

NAME OF PROVIDER OR SUPPLIER: PENN HIGHLANDS JEFFERSON MANOR STATE LICENSE NUMBER: 100802	STREET ADDRESS, CITY, STATE, ZIP CODE: 417 ROUTE 28 BROOKVILLE, PA 15825
---	--

(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
P 1490	<p>Personnel policies and procedures.</p> <p>(6) Documentation of the employee's orientation to the facility and the employee's assigned position prior to or within 1 week of the employee's start date.</p> <p>This REGULATION is not met as evidenced by:</p>	P 1490	<p>The facility identified a break down in the orientation process effecting non-clinical staff. IDT (Interdisciplinary Team) team has been educated on providing effective, facility- based orientation to all staff upon hire. All staff employed at the building were provided a facility-based orientation to determine they have the proper resources and education.</p> <p>Facility looked back 4 months to identify any staff members that did not receive the adequate orientation to the facility and provided them this information</p> <p>Moving forward the Nursing Home Administrator (NHA) or designee will audit 50% of new hire files to determine facility-based orientation is being provided. This process will be reviewed in our Quality Assurance Performance Improvement (QAPI) plan and updated as needed based on ongoing audits.</p>	<p>Completion Date: 03/10/2025</p> <p>Status: APPROVED</p> <p>Date: 01/31/2025</p>

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395626	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/09/2025
NAME OF PROVIDER OR SUPPLIER: PENN HIGHLANDS JEFFERSON MANOR STATE LICENSE NUMBER: 100802		STREET ADDRESS, CITY, STATE, ZIP CODE: 417 ROUTE 28 BROOKVILLE, PA 15825		
(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
P 1490	Continued from page 1 Based on review of employee personnel records and staff interview, it was determined that the facility failed to ensure that employees received orientation to the facility and the employee's position prior to or within one week of the employee's start date for three of five employee records reviewed (Dietary Aide Employee E3, Housekeeping Aide Employee E4, and Nurse Aide Employee E5). Findings include: Facility employee records revealed that Dietary Aide Employee E3 began working with the facility on 8/27/24. Further review of employee records failed to contain evidence that Dietary Aide Employee E3 received orientation prior to or within one week of his/her start date. Facility employee records revealed that Housekeeping Aide Employee E4 began working with the facility on 8/01/24. Further review of employee records failed to contain evidence that	P 1490		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395626	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 01/09/2025
NAME OF PROVIDER OR SUPPLIER: PENN HIGHLANDS JEFFERSON MANOR STATE LICENSE NUMBER: 100802		STREET ADDRESS, CITY, STATE, ZIP CODE: 417 ROUTE 28 BROOKVILLE, PA 15825		
(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
P 1490	Continued from page 2 Housekeeping Aide Employee E4 received orientation prior to or within one week of his/her start dated. Facility employee records revealed that Nurse Aide Employee E5 began working with the facility on 10/15/24. Further review of employee records failed to contain evidence that Nurse Aide Employee E5 received orientation prior to or within one week of his/her start dated. During an interview on 1/08/25, at 8:59 a.m. the Nursing Home Administrator (NHA) confirmed that Dietary Aide Employee E3, Housekeeping Aide Employee E4, and Nurse Aide Employee E5's employee records lacked evidence that they received required orientation prior to or within one week of his/her start date.	P 1490		



Certified End Page

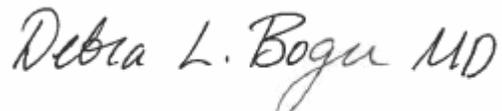
PENN HIGHLANDS JEFFERSON MANOR

STATE LICENSE NUMBER: 100802

SURVEY EXIT DATE: 01/09/2025

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