STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395626	A. BLDG: __--_____ B. WING: _____	01/14/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
E 0000	INITIAL COMMENT Based on an Emergency Preparedness Survey completed on January 14, 2025, at Penn Highlands Jefferson Manor, it was determined there were no deficiencies identified with the requirements of 42 CFR 483.73.	E 0000		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

Certified End Page

PENN HIGHLANDS JEFFERSON MANOR

STATE LICENSE NUMBER: 100802

SURVEY EXIT DATE: 01/14/2025

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
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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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K 0000	INITIAL COMMENT Facility ID #100802 Component 01 Main Building Based on a Medicare/Medicaid Recertification Survey completed on January 14, 2025, it was determined that Penn Highlands Jefferson Manor was not in compliance with the requirements of the Life Safety Code for an existing health care occupancy. Compliance with the National Fire Protection Association's Life Safety Code is required by 42 CFR 483.90(a). This is a three-story, Type II (222), fire resistive building, that is fully sprinklered.	K 0000		
K 0223 SS=E		K 0223		

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

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K 0223 SS=E	Continued from page 1 NFPA 101 Doors with Self-Closing Devices Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by:	K 0223	Maintenance staff have been educated on the need for proper operating functions of self closing doors and how to identify the need for them. Self- Closing doors have been ordered and will be placed on each door This process will be audited in our Quality Assurance Performance Improvement Plan Quarterly with random auditing performed by the maintenance director to ensure self closing door are in operation and closing appropriately	Completion Date: **02/25/2025** Status: **APPROVED** Date: **02/10/2025**

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K 0223 SS=E	Continued from page 2 Based on observation and interview, the facility failed to maintain doors with self-closing devices on four of over twenty floors. Findings include: Observation on January 14, 2025, between 9:58 a.m. and 10:44 a.m., revealed the following self-closing door deficiencies: A. (9:58 a.m.) The kitchen door to the trash hall failed to latch in the frame; B. (10:15 a.m.) Basement corridor doors near the laundry had self-closing device disconnected, and the door failed to close and latch in the frame; C. (10:25 a.m.) Laundry door between the wet and dry rooms failed to latch in the frame; D. (10:44 a.m.) The corridor door to the therapy room had self-closing device disconnected, and the door failed to close and latch in the frame. Interview with the maintenance supervisor on January 14, 2025, at 10:44 a.m., confirmed the self-closing door deficiencies.	K 0223		

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K 0223 SS=E	Continued from page 3	K 0223		
K 0293 SS=C	NFPA 101 Exit Signage Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by:	K 0293	Facility removed the signage front door identifying it to not be an exit. Additional exit signage has been placed around the nursing stations and residents area to provide detailed signage for exiting the building. This information was reviewed in resident council as well as all-staff education.	Completion Date: **03/01/2025** Status: **APPROVED** Date: **02/05/2025**

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K 0293 SS=C	Continued from page 4 Based on observation and interview, the facility failed to maintain exit signs on three of three floors. Findings include: Observation on January 14, 2025, between 9:31 a.m. and 10:41 a.m., revealed the following exit sign deficiencies: A. (10:37 a.m.) First floor, main lobby, had missing exit signs directing to the main door; B. (10:38 a.m.) First floor, main lobby, front entrance door was labeled "not a fire exit"; C. (10:50 a.m.) Second-floor, center core, had missing exit signs around the nurse station; D. (11:07 a.m.) Third-floor, center core, had missing exit signs around the nurse station. Interview with the maintenance supervisor on January 14, 2025, at 10:41 a.m., confirmed the exit sign deficiencies.	K 0293		

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K 0353 SS=F	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by:	K 0353	The sprinkler head identified was cleaned. Maintenace director advised Maintenace staff that all other sprinkler heads to be reviewed and cleaned. Audits of 10 ranndom sprinklers will be done weekly for 6 weeks to ensure cleanliness and free of debris. Audits will them be monthly thereafter.	Completion Date: 03/01/2025 Status: APPROVED Date: 02/05/2025

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K 0353 SS=F	Continued from page 6 Based on observation and interview, the facility failed to maintain the sprinkler system for one of one system. Findings include: Observation on January 14, 2025, between 9:57 a.m. and 10:23 a.m., revealed the following sprinkler system deficiencies: A. (9:57 a.m.) Kitchen dishwashing area had a dirty sprinkler head, dirt and debris can reduce the efficiency of sprinkler during an emergency; B. (10:05 a.m.) Mechanical room, near the boilers in the ceiling, wires and cables were attached to the sprinkler system; C. (10:23 a.m.) Laundry room had sprinkler heads that were dust-covered and dirty, dirt and debris can reduce the efficiency of sprinklers during an emergency. Interview with the maintenance supervisor on January 14, 20255, at 10:23 a.m., confirmed the sprinkler head deficiencies existed at the time of the survey.	K 0353		

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K 0353 SS=F	Continued from page 7	K 0353		
K 0372 SS=E	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by:	K 0372	Ceiling tiles were replaced as advised. Maintenance staff educated on replacing ceiling tiles during & after providing maintenance services to ensure a proper smoke barrier. maintenace director will audit for missing tiles weekly for 6 weeks and monthly thereafter	Completion Date: **03/01/2025** Status: **APPROVED** Date: **02/05/2025**

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K 0372 SS=E	Continued from page 8 Based on observation and interview, the facility failed to maintain smoke barrier requirements on one of three wings. Findings include: Observation on January 14, 2025, at 9:54 a.m., revealed the facility failed to maintain smoke barriers on the main floor, kitchen dishwashing area. There were missing ceiling tiles present, allowing the transfer of smoke. Interview with the maintenance supervisor on January 14, 2025, at 9:54 a.m., confirmed the smoke barrier deficiency.	K 0372		
K 0521 SS=F		K 0521		

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K 0521 SS=F	Continued from page 9 NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by:	K 0521	Maintenance director and maintenance department staff educated on the deficiency and proper timeliness of maintenance. fire/ smoke damper inspection has been scheduled to be performed and will be scheduled from there on. Nursing Home Administrator will set reminder to ensure this process is completed within the appropriate range to meet regulatory standards. This process will be reviewed in our Quality Assurance Performance Improvement Plan Quarterly for Performance Improvement.	Completion Date: **03/01/2025** Status: **APPROVED** Date: **02/10/2025**

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K 0521 SS=F	Continued from page 10 Based on document review and interview, the facility failed to maintain heating, ventilating, and air conditioning (HVAC) equipment, affecting the entire facility. Findings include: Document review on January 14, 2025, at 10:50 a.m., revealed the facility failed to provide documentation that the fire/smoke damper inspection was performed within the previous four years. Interview with the maintenance supervisor on January 14, 2025, at 10:50 a.m., confirmed the documentation was unavailable at the time of the survey.	K 0521		
K 0753 SS=B		K 0753		

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K 0753 SS=B	Continued from page 11 NFPA 101 Combustible Decorations Combustible Decorations Combustible decorations shall be prohibited unless one of the following is met: o Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. o Decorations meet NFPA 701. o Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. o Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6(4) or 19.7.5.6(4). o The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present. 19.7.5.6 This REQUIREMENT is not met as evidenced by:	K 0753	The decorative item was removed from the door. All doors in the facility were checked to ensure the allowable coverage was not compensated. All-staff educated in monthly inservice meetings of code and appropriate allotment of coverage along with advising maintenance when something is on a door. NHA & facility maintenance director will audit weekly for one monthly and monthly thereafter.	Completion Date: **03/01/2025** Status: **APPROVED** Date: **02/05/2025**

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K 0753 SS=B	Continued from page 12 Based on observation and interview, the facility failed to maintain combustible decorations on one of over fifteen resident room doors. Findings include: Observation on January 14, 2025, at 11:02 a.m., revealed the fire doors in the Walnut Street wing, near resident room #245, had decorations that exceeded allowable coverage of materials. The decorations also had no documentation that fire, flame, or smoke-proofing applications were applied to them. Interview with the maintenance supervisor on January 14, 2025, at 11:02 a.m., confirmed the combustible decoration deficiency existed at the time of the survey.	K 0753		
K 0912 SS=B		K 0912		

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K 0912 SS=B	Continued from page 13 NFPA 101 Electrical Systems - Receptacles Electrical Systems - Receptacles Power receptacles have at least one, separate, highly dependable grounding pole capable of maintaining low-contact resistance with its mating plug. In pediatric locations, receptacles in patient rooms, bathrooms, play rooms, and activity rooms, other than nurseries, are listed tamper-resistant or employ a listed cover. If used in patient care room, ground-fault circuit interrupters (GFCI) are listed. 6.3.2.2.6.2 (F), 6.3.2.2.4.2 (NFPA 99) This REQUIREMENT is not met as evidenced by:	K 0912	The receptacle was taken out of use and replaced with an appropriate, code quality receptacle. Maintenance director and staff educated on code. Maintenance director will audit all other areas of building to determine we are in compliance with code	Completion Date: **03/01/2025** Status: **APPROVED** Date: **02/05/2025**

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K 0912 SS=B	Continued from page 14 Based on observation and interview, the facility failed to maintain electrical receptacles in one of over twenty rooms. Findings include: Observation on January 14, 2025, at 9:38 a.m., revealed the facility failed to ensure ground fault circuit interrupter (GFCI) protection in the chemical storage room on the first floor. An unprotected receptacle was present within six feet of the water basin. Interview with the maintenance supervisor on January 14, 2025, at 9:38 a.m., confirmed the electrical outlet deficiency.	K 0912		
K 0923 SS=D		K 0923		

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
K 0923 SS=D	Continued from page 15 NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders	K 0923	Oxygen tank identified was secured, Facility was checked to determine in any other oxygen cylinders were unsecured and did not determine any. All staff were educated on the procedure for securing an oxygen cylinder as well as the appropriate labeling of the tank. Maintenance director will audit tanks weekly for 6 weeks and monthly there after	Completion Date: **03/01/2025** Status: **APPROVED** Date: **02/05/2025**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	395626	A. BLDG: __01_____ B. WING: _____	01/14/2025

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K 0923 SS=D	Continued from page 16 are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain gas equipment storage requirements in one of four rooms. Findings Include: Observation on January 14, 2025, at 9:31 a.m., revealed the first-floor staffing office had an oxygen cylinder that was not properly secured or labeled as full or empty. Interview with the maintenance supervisor on January 14, 2025, at 9:31 a.m., confirmed the above gas equipment storage deficiency.	K 0923		

Certified End Page

PENN HIGHLANDS JEFFERSON MANOR

STATE LICENSE NUMBER: 100802

SURVEY EXIT DATE: 01/14/2025

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
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