pennsylvania
DEPARTMENT OF HUMAN SERVICES

CERTIFICATE OF COMPLIANCE

This certificate is hereby granted to **JEFFCO HEALTH SERVICES INC**
LEGAL ENTITY

To operate **PENN HIGHLANDS JEFFERSON MANOR P. C.**
NAME OF FACILITY OR AGENCY

Located at **417 RT. 28, BROOKVILLE, PA 15825**
(COMPLETE ADDRESS OF FACILITY OR AGENCY)

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

ADDRESS OF SATELLITE SITE/SERVICE LOCATION

PROVISIONAL

To provide **Personal Care Homes**
TYPE OF SERVICE(S) TO BE PROVIDED

The total number of persons which may be cared for at one time may not exceed **48** (MAXIMUM CAPACITY)
or the maximum capacity permitted by the Certificate of Occupancy, whichever is smaller.

Restrictions: **Secure Dementia Care Unit - 55 Pa.Code §§ 2600.231-239 - Capacity 24**

This certificate is granted in accordance with the Human Services Code of 1967, P.L. 31, as amended, and Regulations

55 Pa.Code Chapter 2600: Personal Care Homes
(MANUAL NUMBER AND TITLE OF REGULATIONS)

and shall remain in effect from **December 30, 2025** until **June 30, 2026**,
unless sooner revoked for non-compliance with applicable laws and regulations.

No: **406242**

ISSUING OFFICER

Juliet Marsala
ACTING DEPUTY SECRETARY

NOTE: This certificate is issued for the above site(s) only and is not transferable and should be posted in a conspicuous place in the facility.

Pennsylvania
Department of Human Services

CERTIFIED MAIL – RETURN RECEIPT REQUESTED
MAILING DATE: DECEMBER 30, 2025
Email: [redacted]

[redacted]
Jeffco Health Services Inc.
417 Route 28
Brookville, Pennsylvania 15825

RE: Penn Highlands Jefferson Manor P.C.
License/COC #: 406242

Dear [redacted]:

As a result of the Pennsylvania Department of Human Services, Bureau of Human Services Licensing, (Department) licensing inspections on July 8, 2025, July 9, 2025, August 28, 2025, October 31, 2025, and November 6, 2025, of the above facility, the violations specified on the enclosed Licensing Inspection Summary (LIS) were found.

Based on violations with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), the Department hereby issues you a SECOND PROVISIONAL license to operate the above facility. A SECOND PROVISIONAL license is being issued based on your acceptable plan to correct the violations as specified on the LIS. This decision is made pursuant to 62 P.S. § 1026 (b)(1) ;(4) ;(5) and 55 Pa. Code § 20.71(a)(2) ;(3) ;(4) ;(5) ;(6) (relating to conditions for denial, nonrenewal or revocation). Your SECOND PROVISIONAL license is enclosed and is valid from DECEMBER 30, 2025 to JUNE 30, 2026.

All violations specified on the LIS must be corrected by the dates specified on the report and continued compliance with 55 Pa. Code Ch. 2600 (relating to Personal Care Homes), must be maintained. Failure to implement the plan of correction or failure to maintain compliance may result in a revocation of the license.

Pursuant to 62 P.S. 1085-1087 and 55 Pa. Code § 2600.261-268 (relating to enforcement), the Department intends to assess a fine for the following violation(s) unless fully corrected on or before the mandated correction date.

55 Pa. Code Chapter 2600 Section:	Class of Violation	Census at Inspection	Fine Per resident X Per day	Calculated Fine = Per day	Mandated Correction Date (to avoid Fine)
15(a)	III	23	$3	$69	15 calendar days From the date of This letter.
187(d)	III	23	$3	$69	15 calendar days From the date of This letter.

A fine will be assessed daily beginning with the date of this letter and will continue until the violation is fully corrected, and full compliance with the regulation has been achieved. If the violation is fully corrected, and full compliance with the regulation has been achieved, by the mandated correction date, no fine will be assessed. You must notify the Department's Regional Human Services Licensing office in writing as soon as each violation is fully corrected and submit written documentation of each correction. The Department will conduct an on-site inspection after the mandated correction date, and within 20 calendar days of the date of this letter. If one or more violations is not fully corrected and full compliance with the regulation has not been achieved, you will periodically receive invoices from the Department's Bureau of Human Services Licensing with payment instructions. The fines will continue to accumulate until the violation is fully corrected and full compliance with the regulation has been achieved.

No fine is being assessed at this time; therefore, you may not appeal any fine at this time. If a violation is not corrected and full compliance with the regulation has not been achieved by the mandated correction date, a fine will be assessed and an invoice will be mailed. This invoice will contain the right to appeal the fine.

If you disagree with the decision to issue a SECOND PROVISIONAL license, you have the right to appeal through hearing before the Bureau of Hearings and Appeals, Department of Human Services in accordance with 1 Pa. Code Part II, Chapters 31-35.

If you decide to appeal your SECOND PROVISIONAL license, a written request for an appeal must be received within 10 days of the date of this letter by:

Pennsylvania Department of Human Services
Bureau of Human Services Licensing
Room 631, Health and Welfare Building

625 Forster Street
Harrisburg, Pennsylvania 17120
PH: 717-265-8942

This decision is final 11 days from the date of this letter, or if you decide to appeal, upon issuance of a decision by the Bureau of Hearings and Appeals.

Sincerely,

Juliet Marsala
Deputy Secretary
Office of Long-term Living

Enclosure
Licensing Inspection Summary

cc:

Department of Human Services
Bureau of Human Service Licensing
LICENSING INSPECTION SUMMARY - PUBLIC

Facility Information

Name: *PENN HIGHLANDS JEFFERSON MANOR P. C.* **License #**: *40624* **License Expiration**: *10/11/2025*

Address: *417 RT. 28, BROOKVILLE, PA 15825*

County: *JEFFERSON* **Region**: *WESTERN*

Administrator

Name:

Legal Entity

Name: *JEFFCO HEALTH SERVICES INC*

Address: *417 RT. 28, BROOKVILLE, PA, 15825*

Phone:

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *02/09/1994* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *46* **Waking Staff**: *35*

Inspection Information

Type: *Full* **Notice**: *Unannounced* **BHA Docket #**:

Reason: *Complaint, Provisional, Incident* **Exit Conference Date**: *07/09/2025*

Inspection Dates and Department Representative

07/08/2025 - On-Site:
07/09/2025 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *48* **Residents Served**: *29*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *second floor* **Capacity**: *24* **Residents Served**: *15*

Hospice

Current Residents: *5*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *29*

Diagnosed with Mental Illness: *22* **Diagnosed with Intellectual Disability**: *1*

Have Mobility Need: *17* **Have Physical Disability**: *0*

Inspections / Reviews

07/08/2025 - Full

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *08/10/2025*

08/19/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *08/05/2025*

Reviewer: [redacted] **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *08/26/2025*

09/06/2025 - POC Submission

Submitted By: [redacted] **Date Submitted**: *08/20/2025*

Reviewer: [redacted] **Follow-Up Type**: *Document Submission* **Follow-Up Date**: *09/15/2025*

12/10/2025 - Document Submission

Submitted By: [redacted] **Date Submitted**: *09/15/2025*

Reviewer: [redacted] **Follow-Up Type**: *Enforcement*

15a - Resident Abuse Report

1. Requirements

2600.
15.a. The home shall immediately report suspected abuse of a resident served in the home in accordance with the Older Adult Protective Services Act (35 P. S. § § 10225.701—10225.707) and 6 Pa. Code § 15.21—15.27 (relating to reporting suspected abuse) and comply with the requirements regarding restrictions on staff persons.

Description of Violation

Progress notes indicate that on [redacted]/25 at 7:34 p.m., resident #1 reported to staff that [redacted] punched resident #2 in the face while resident #2 was on the toilet. Staff checked on resident #2 and the resident indicated [redacted] was punched. However, this allegation of abuse was not reported to the local Area Agency on Aging.

Repeat Violation: 7/23/2024

Plan of Correction ***Accept [redacted] - 09/06/2025)***

On 7/10/2025 [redacted] the administrator called and reported the suspected abuse to the local Area Agency on Aging.
On 7/15/2025 [redacted] the administrator gave education to the staff on reporting suspected abuse and the proper way to go about reporting it.
Starting on 7/9/2025 the administrator or designated person will immediately call to report all abuse to the local Area Agency on Aging and DHS as soon as it happens. Starting on 7/9/2025 the administrator or designated person will submit a mandatory abuse reporting form to the local area of agency on aging within 48 hours of abuse.
Starting on 7/9/2025 the administrator will give annual education to all staff on how and when to report to the local area of agency.
Starting on 8/20/2025 the administrator and the resident care coordinator will review all abuse allegations weekly.

Licensee's Proposed Overall Completion Date: *08/20/2025*

Not Implemented [redacted] - 12/03/2025)

16c - Written Incident Report

2. Requirements

2600.
16.c. The home shall report the incident or condition to the Department's personal care home regional office or the personal care home complaint hotline within 24 hours in a manner designated by the Department. Abuse reporting shall also follow the guidelines in § 2600.15 (relating to abuse reporting covered by law).

Description of Violation

Progress notes indicate that on [redacted]/25 at 7:34 p.m., resident #1 reported to staff that [redacted] punched resident #2 in the face while the resident was on the toilet. Staff checked on resident #2 and the resident indicated [redacted] was punched. However, this allegation of abuse was not reported to the Department.

Plan of Correction ***Accept [redacted] - 09/06/2025)***

On 7/10/2025 [redacted] the administrator called and reported the suspected abuse to the local Area Agency on Aging.

16c - Written Incident Report (continued)

On 7/15/2025 [redacted] the administrator gave education to the staff on reporting suspected abuse and the proper way to go about reporting it.
Starting on 7/9/2025 the administrator or designated person will report all abuse to the department within 24 hours of the incident.
Starting on 9/1/2025 the administrator will monitor and review all incidents and conditions to ensure reportable incident and conditions are reported to the department within 24 hours. Documentation will be kept.
On 8/19/2025 the administrator gave training to the staff on requirements to report reportable incidents to the department within 24 hours and how to properly document.

Licensee's Proposed Overall Completion Date: *08/20/2025*

***Implemented** ([redacted] - 12/3/2025)*

17 - Record Confidentiality

3. Requirements

2600.
17. Resident records shall be confidential, and, except in emergencies, may not be accessible to anyone other than the resident, the resident's designated person if any, staff persons for the purpose of providing services to the resident, agents of the Department and the long-term care ombudsman without the written consent of the resident, an individual holding the resident's power of attorney for health care or health care proxy or a resident's designated person, or if a court orders disclosure.

Description of Violation

On 7/8/25 at 11:00 a.m., multiple residents' medical information, to include resident #3's medication orders, were unlocked, unattended, and accessible in a binder on the shelf of the personal care nurse's station in the main entrance area.

On 7/8/25 at 11:15 a.m., multiple residents' medical information, to include resident #3 and resident #4's medication pharmacy labels, were unlocked, unattended, and accessible on the second shelf of the Secure Dementia Care Unit nurse's station.

Plan of Correction ***Accept ([redacted] 08/19/2025)***

On 7/9/2025 the administrator [redacted] gathered all the medical information on the PC nurses' desk and SDU nurses' desk and locked them up in locking binder boxes.
On 7/15/2025 the administrator [redacted] gave education to the staff on keeping resident information under lock and key and not accessible to others.
Starting 8/1/2025 weekly the resident care coordinator will check the nurses desk to ensure that there is no resident information on the desks, after a month the resident care coordinator will check monthly.

Licensee's Proposed Overall Completion Date: *08/04/2025*

Not Implemented ([redacted] - 12/03/2025)

23a - Activities of Daily Living Assistance

4. Requirements

23a - Activities of Daily Living Assistance *(continued)*

2600.
23.a. A home shall provide each resident with assistance with ADLs as indicated in the resident’s assessment and support plan.

Description of Violation

Resident #1 resides in the Secure Dementia Care Unit. The resident assessment and support plan, dated [redacted]/25 for resident #1, indicates the resident requires extensive supervision, cannot leave the home unattended, and is unaware of unsafe areas. To meet these needs, staff with provide 1 hour wellness checks and are responsible for monitoring the whereabouts of the resident. On 6/4/25 at approximately 4:55 p.m., resident #1 did not receive this assistance as required. The resident climbed a ladder in the Secure Dementia Care Unit's exterior courtyard, accessed the roof, and was found walking around on the roof by staff around 5:00 p.m.

Plan of Correction ***Directed [redacted] - 09/06/2025)***

On 6/4/2025 emergency services were dispatched and with their help staff were able to get resident #1 off of the roof and to safety.
On 6/4/2025 the administrator [redacted] reported the situation to the local Area Agency on Aging and DHS and implemented 15-minute safety checks on resident #1 as well as door checks to ensure safety.
Starting on 6/5/2025 DCS will continue to do 15-minute safety checks on resident #1 every shift until further notice.
Starting on 8/20/2025 the administrator will review the schedule and staffing levels to ensure adequate number of dcs are scheduled and present in the home at all times.
Starting on 9/10/2025 the administrator will meet with all dcs and review the needs of the residents.

Proposed Overall Completion Date: 08/04/2025
Proposed Overall Completion Date: 08/20/2025

Directed:
By 9/10/25 and weekly thereafter, the administrator will review the schedule and staffing levels to ensure an adequate number of direct care staff are scheduled and present in the home at all times to meet the needs of the residents as specified in the assessment and support plan. Documentation will be kept.
[redacted] 9/6/25

Directed:
By 9/10/25 and monthly thereafter, the administrator will meet with all direct care staff and review the needs of each resident for whom the staff provides direct care, as indicated in the RASP, to ensure all resident’s needs are met. Reviews will be done with all new hires prior to performing direct care, and all direct care staff within 24 hours of any significant change RASPs. Documentation of reviews will be kept.
[redacted] 9/6/25

Directed Completion Date: *09/10/2025*

Implemented [redacted] - 12/03/2025)

25b - Contract Signatures

5. Requirements

2600.
25.b. The contract shall be signed by the administrator or a designee, the resident and the payer, if different from the resident, and cosigned by the resident's designated person if any, if the resident agrees.

Description of Violation

The resident-home contract, dated [redacted] 25 for resident #1, was not signed by the payer.

Plan of Correction ***Accept [redacted] - 09/06/2025)***

On 7/10/2025 resident #1s payor which is [redacted] and designated person was given education on the importance of signing and that it would come back on [redacted] or [redacted] assets in the event that bill needed to be paid. And that [redacted] needed to sign the payor portion of the contract.
On 7/15/2025 education was given to the resident care coordinator on why the contracts needed to be signed in full.
Starting on 9/1/2025 the administrator will audit all current contracts quarterly to ensure that they are signed in completion and continue audits for all new residents that come into facility.
On 8/23/2025 the [redacted] is coming in to sign the payer portion of the contract.

Licensee's Proposed Overall Completion Date: *08/20/2025*

Not Implemented [redacted] - 12/03/2025)

25c4 - Payment Responsibility

6. Requirements

2600.
25.c. At a minimum, the contract must specify the following:
4. The party responsible for payment.

Description of Violation

The resident-home contract, dated [redacted] /25 for resident #1, does not specify the party responsible for payment.

Plan of Correction ***Accept [redacted] - 09/06/2025)***

On 7/10/2025 resident #1s payor which is [redacted] and designated person was given education on the importance of signing and that it would come back on [redacted] or [redacted] assets in the event that bill needed to be paid. And that [redacted] needed to sign the payor portion of the contract.
On 7/15/2025 education was given to the resident care coordinator on why the contracts needed to be signed in full.
Starting on 9/1/2025 the administrator will audit all current contracts to ensure that they are signed in completion and continue audits for all new residents that come into facility.
On 8/23/2025 the [redacted] is coming in to sign the payer portion of the contract.

Licensee's Proposed Overall Completion Date: *08/20/2025*

Implemented [redacted] - 12/03/2025)

42b - Abuse

7. Requirements

2600.

42b - Abuse *(continued)*

42.b. A resident may not be neglected, intimidated, physically or verbally abused, mistreated, subjected to corporal punishment or disciplined in any way.

Description of Violation

Resident #1 resides in the Secure Dementia Care Unit. [redacted] resident assessment and support plan, dated [redacted]/25, indicates [redacted] has a moderate problem with [redacted] decisions being harmful to self or others. Resident #1's 4/30/25 progress notes indicate the resident is not understanding the concept of staying out of resident rooms and staff had to redirect the resident several times to stop [redacted] from getting into other rooms. Resident #5 resides in the Secure Dementia Care Unit.

Staff interviews indicate on 5/6/25 at 7:30 p.m., resident #1 was in resident #5's bedroom. Resident #5 confronted resident #1 about being in [redacted] bedroom, and resident #1 grabbed and pushed resident #5, causing resident #5 to hit the wall with a loud thud. Resident #5 attempted to push resident #1 back; however, resident #1 pushed resident #5 again. Resident #5 lost [redacted] balance and [redacted] head on the door. Resident #5 was sent to the hospital and diagnosed with a head laceration.

Plan of Correction ***Directed [redacted] - 09/06/2025)***

On 7/10/2025 [redacted] the administrator reported the situation to the local Area Agency on Aging.
On 7/15/2025 [redacted] the administrator gave education to all of her staff on how to properly document and report any suspected or actual abuse.
Starting on 8/1/2025 [redacted] the administrator will do annual training with her staff on how to document and report abuse.
Starting on 9/1/2025 the administrator will monitor and review all behavioral documentation and the RASP to ensure that the residents are being adequately cared for.
Starting on 8/20/2025 the administrator will review the schedule and staffing levels to ensure adequate number of dcs are scheduled and present in the home at all times.
Starting on 9/10/2025 the administrator will meet with all dcs and review the needs of the residents.

Proposed Overall Completion Date: 08/20/2025

Directed:
By 9/30/25 and monthly thereafter, the administrator will review the home's documentation of resident behaviors and each resident's assessment and support plan carefully, especially for supervision, mental and behavioral health, and social and recreational needs to ensure the home is adequately providing care and services which meet the needs of the residents. Any significant changes identified will be documented on the assessment with support plan revisions within 24 hours.
[redacted] 9/6/25

Directed
By 9/10/25 and weekly thereafter, the administrator will review the schedule and staffing levels to ensure an adequate number of direct care staff are scheduled and present in the home at all times to meet the needs of the residents as specified in the assessment and support plan. Documentation will be kept.
[redacted] 9/6/25

Directed:
By 9/10/25 and monthly thereafter, the administrator will meet with all direct care staff and review the needs of

42b - Abuse (continued)

each resident for whom the staff provides direct care, as indicated in the RASP, to ensure all resident's needs are met. Reviews will be done with all new hires prior to performing direct care, and all direct care staff within 24 hours of any significant change RASPs. Documentation of reviews will be kept.
9/6/25

Directed Completion Date: *09/30/2025*

Not Implemented - 12/03/2025)

60a - Staff/Support Plan

8. Requirements

2600.
60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan.

Description of Violation

On 5/6/25, the home served 29 residents, 15 of whom reside on the 2nd floor Secure Dementia Care Unit and have mobility needs, including resident #1 who is exit seeking, and 14 of whom reside on the 1st floor personal care, including 2 residents with mobility needs, including resident #6, who requires 2-person assistance for safety. From 10:00 p.m. on 5/6/25 to 5:00 a.m. on 5/7/25, only 2 staff were present, which is inadequate to safely evacuate and supervise all residents in the event of an emergency.

Plan of Correction ***Directed - 09/06/2025)***

On 7/10/2025 the resident care coordinator added onto the schedule for staff members to pick up shifts for the 10p-6a shift so that there were three staff members on that shift.
On 7/10/2025 the administrator gave education to the resident care coordinator on the appropriate amount of staffing that is needed per mobility needs.
Starting on 9/1/2025 and ongoing the resident care coordinator will start to schedule 3 staff members on the 10p-6a shift and adding in needs for staff to pick up to ensure that there are enough staff members per resident mobility needs.
Starting on 8/20/2025 the administrator will review the schedule and staffing levels to ensure adequate number of dcs are scheduled and present in the home at all times.

Proposed Overall Completion Date: 08/20/2025

Directed:
By 9/10/25 and weekly thereafter, the administrator will review the schedule and staffing levels to ensure an adequate number of direct care staff are scheduled and present in the home at all times to meet the needs of the residents as specified in the assessment and support plan. Documentation will be kept.
9/6/25

Directed Completion Date: *09/10/2025*

Not Implemented - 12/03/2025)

65g - Annual Training Content

10. Requirements

65g - Annual Training Content *(continued)*

2600.
65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:

1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.
2. Emergency preparedness procedures and recognition and response to crises and emergency situations.
3. Resident rights.
4. The Older Adult Protective Services Act (35 P.S. § § 10225.101—10225.5102).
5. Falls and accident prevention.
6. New population groups that are being served at the home that were not previously served, if applicable.

Description of Violation

Staff person A did not receive training in Fire safety by a fire safety expert or staff trained by a fire safety expert and Older Adult Protective Services Act (OAPSA) during training year 1/1/24 to 12/31/24.

Staff person B did not receive training in Fire safety by a fire safety expert or staff trained by a fire safety expert during training year 1/1/24 to 12/31/24.

Staff person C did not receive any of the required training for 2600.65g during training year 1/1/24 to 12/31/24.

Repeat Violation: 10/1/2024

Plan of Correction ***Accept [redacted] - 09/06/2025)***

On 6/5/2025 staff person C [redacted] and cannot receive any further trainings.
On 5/21/2025 all staff were given fire safety training by the fire chief for the volunteer fire department in the community.
On 7/10/2025 the administrator [redacted] gave education to the stand in maintenance men on what kind of fire safety training was needed.
Starting on 9/1/2025 the administrator [redacted] will ensure that annual trainings are given to all new staff members, ancillary staff, and volunteers. That fire safety training is done annually, and fire safety orientation is done upon hire by a fire safety expert.
On 7/15/2025 the administrator [redacted] gave training to staff person A on (OAPSA).
Starting on 8/1/2025 the administrator [redacted] will audit the employee files to ensure they have the trainings that they are missing in 2024 and continue the training through 2025 and on monthly. Audit to be completed by 9/1/2025.

Licensee's Proposed Overall Completion Date: *08/20/2025*

Not Implemented [redacted] - 12/03/2025)

89b - Hot Water Temperature

12. Requirements

89b - Hot Water Temperature *(continued)*

2600.
89.b. Hot water temperature in areas accessible to the resident may not exceed 120°F.

Description of Violation

On 7/8/25 at 10:50 a.m., the hot water temperature at the personal care shower room sink was 128.7 degrees Fahrenheit.

On 7/8/25 at 11:13 a.m., the hot water temperature at the bathroom sink in bedroom #17 was 125.8 degrees Fahrenheit.

Plan of Correction ***Accept - 09/06/2025)***

On 7/9/2025 the administrator had the maintenance n turn the hot water tank down to ensure that the water does not exceed 120 degrees Fahrenheits.
On 7/10/2025 the administrator checked different areas of the buildings water to ensure that it did not exceed 120 degrees Fahrenheits.
Starting on 9/1/2025 water temps will be checked at different places in the building by DCS each shift as part of their shift duties to ensure that the water temperature does not exceed 120 degrees Fahrenheits. Documentation will be kept and any temperature exceeding 120 degrees fahrenheit will immediately be reported to the administrator and immediate action will be taken to reduce the temperature.

Licensee's Proposed Overall Completion Date: *08/20/2025*

Implemented - 12/03/2025)

100a - Exterior - Free of Hazards

13. Requirements

2600.
100.a. The exterior of the building and the building grounds or yard must be in good repair and free of hazards.

Description of Violation

On 6/4/25 at approximately 4:55 p.m., resident #1 climbed a ladder in the Secure Dementia Care Unit's exterior courtyard, accessed the roof, and was found walking around on the roof by staff around 5:00 p.m.

Plan of Correction ***Accept - 09/06/2025)***

On 6/4/2025 the ladder was removed from the secure dementia unit by the resident care coordinator
On 6/5/2025 the resident care coordinator did building rounds to ensure that the grounds and yard were in good repair and free of hazards.
Starting on 9/1/2025 the maintenance of the building will do weekly ground walks to ensure that the exterior of the building and the building grounds or yard are in good repair and free of hazards and documentation will be kept.

Licensee's Proposed Overall Completion Date: *08/20/2025*

Not Implemented - 12/03/2025)

101j7 - Lighting/Operable Lamp

14. Requirements

2600.
101.j. Each resident shall have the following in the bedroom:
7. An operable lamp or other source of lighting that can be turned on at bedside.

Description of Violation

On 7/8/25, resident #5 did not have a source of light that can be turned on/off at bedside.

Plan of Correction ***Accept - 09/06/2025)***

On 7/10/2025 the resident care coordinator put a lamp at the bedside of resident #5.
On 7/11/2025 the resident care coordinator checked to ensure that the lamp was still in place and operable.
Starting on 9/1/2025 the resident care coordinator will do walk in rounds to ensure that each resident has an operable light source at their bedside monthly and documentation will be kept.

Licensee's Proposed Overall Completion Date: *08/20/2025*

Not Implemented - 12/03/2025)

102i - Soap Dispenser

15. Requirements

2600.
102.i. A dispenser with soap shall be provided within reach of each bathroom sink. Bar soap is not permitted unless there is a separate bar clearly labeled for each resident who shares a bathroom.

Description of Violation

On 7/8/25, there were unlabeled used bars of soap on the sink and shelf in the personal care shower room.

Plan of Correction ***Accept - 09/06/2025)***

On 7/10/2025 the unlabeled used bars of soap were removed by .
On 7/11/2025 the resident care coordinator did a facility walk through to ensure that there were no other used bars of soap in the shower rooms.
Starting on 9/1/2025 the administrator will do facility walk throughs monthly to ensure that all residents personal hygiene items are not in the shared bathrooms documentation will be kept

Licensee's Proposed Overall Completion Date: *08/20/2025*

Implemented - 12/03/2025)

103c - Food Protected

16. Requirements

2600.
103.c. Food shall be protected from contamination while being stored, prepared, transported and served.

Description of Violation

On 7/8/25, there were multiple uncovered glasses of orange juice stored in the personal care kitchenette refrigerator.

Plan of Correction ***Accept - 09/06/2025)***

On 7/8/2025 DCS removed the glasses of orange juice that had been found in the personal care kitchenette refrigerator.
On 7/11/2025 the resident care coordinator did a facility walk through to ensure that there were no food or drink

103c - Food Protected (continued)

being stored uncovered in the kitchenette refrigerators.
Starting on 9/1/2025 the DCS will check each shift to ensure that there is no uncovered food or drink being stored in the kitchenette refrigerators documentation will be kept

Licensee's Proposed Overall Completion Date: *08/20/2025*

Not Implemented - 12/03/2025)

103d - Storing Food Off Floor

17. Requirements

2600.
103.d. Food shall be stored off the floor.

Description of Violation

On 7/8/25, a large container of cooking oil was stored on the floor in the skilled nursing/personal care main kitchen, and multiple 5-gallon jugs of emergency water for personal care use were stored on the floor in the storage area of the skilled nursing facility.

Plan of Correction ***Accept - 09/06/2025)***

On 7/8/2025 the kitchen manager immediately removed the cooking oil that was on the floor of the main kitchen.
On 7/9/2025 maintenance put the multiple 5-gallon jugs of emergency water on a table in the storage area of the nursing facility.
On 7/11/2025 the resident care coordinator did a facility walk through to ensure that there was no food or water being stored on the floors of the nursing facility storage area or kitchen.
Starting on 9/1/2025 the maintenance the building will do weekly ground walks to ensure that there is no food or water being stored on the floors of the nursing facility storage area or kitchen documentation will be kept.

Licensee's Proposed Overall Completion Date: *08/20/2025*

Implemented - 12/03/2025)

105g - Lint Removal and Duct Cleaning

19. Requirements

2600.
105.g. To reduce the risks of fire hazards, lint shall be removed from the lint trap and drum of clothes dryers after each use. Lint shall be cleaned from the vent duct and internal and external ductwork of clothes dryers according to the manufacturer's instructions.

Description of Violation

On 7/8/25, there was an approximate 1/8-inch accumulation of lint in the lint trap of dryer #2. There were no clothes in the dryer at the time.

Plan of Correction ***Accept - 09/06/2025)***

On 7/8/2025 the lint was removed from the dyer by housekeeping staff.
On 7/11/2025 the resident care coordinator did a facility walk through to ensure that the dryers had no lint in them.
Starting on 9/1/2025 the housekeeping staff will do weekly checks on the dryers to ensure they are free of lint

105g - Lint Removal and Duct Cleaning (continued)

documentation will be kept

Licensee's Proposed Overall Completion Date: *08/20/2025*

Not Implemented - 12/03/2025)

132a - Monthly Fire Drill

20. Requirements

2600.
132.a. An unannounced fire drill shall be held at least once a month.

Description of Violation

An unannounced fire drill was not held during the months of 11/2024 and 12/2024.

Plan of Correction ***Accept - 09/06/2025)***

On 2/20/2025 the administrator education to the current maintenance on the 2600 regulation pertaining to fire drills.
On 2/20/2025 the administrator created a documented to be used during all fire drills a long with a calendar for the maintenance man to follow conducting fire drills.
Starting on 2/20/2025 the administrator will audit fire drills monthly and ongoing to ensure they are done unannounced monthly documentation will be kept

Licensee's Proposed Overall Completion Date: *08/20/2025*

Not Implemented - 12/03/2025)

132g - Fire Drills Days/Times

21. Requirements

2600.
132.g. Fire drills shall be held on different days of the week, at different times of the day and night, not routinely held when additional staff persons are present and not routinely held at times when resident attendance is low.

Description of Violation

The home routinely schedules 2 staff to work on the 10:00 p.m. to 5;00 a.m. shift, as evidenced by the staff schedule for 5/6/25. However, the least amount of staff participating in fire drills for the past year was 3.

Plan of Correction ***Directed - 09/06/2025)***

On 7/10/2025 the resident care coordinator added onto the schedule for staff members to pick up shifts for the 10p-6a shift so that there were three staff members on that shift.
On 7/10/2025 the administrator gave education to the resident care coordinator on the appropriate amount of staffing that is needed per mobility needs.
Starting on 9/1/2025 and ongoing the resident care coordinator will start to schedule 3 staff members on the 10p-6a shift and adding in needs for staff to pick up to ensure that there are enough staff members per resident mobility needs.
Starting on 8/20/2025 the administrator will review the schedule and staffing levels to ensure adequate number of dcs are scheduled and present in the home at all times.

132g - Fire Drills Days/Times (continued)

Proposed Overall Completion Date: 08/20/2025

Directed:

By 9/10/25 and weekly thereafter, the administrator will review the schedule and staffing levels to ensure an adequate number of direct care staff are scheduled and present in the home at all times to meet the needs of the residents as specified in the assessment and support plan. Documentation will be kept.

9/6/25

Directed Completion Date: *09/10/2025*

Not Implemented - 12/03/2025)

162c - Menus Posted

22. Requirements

2600.
162.c. Menus, stating the specific food being served at each meal, shall be prepared for 1 week in advance and shall be followed. Weekly menus shall be posted 1 week in advance in a conspicuous and public place in the home.

Description of Violation

On 7/8/25, the menu posted in the personal care area was not dated.

Plan of Correction ***Accept (- 09/06/2025)***

On 7/10/2025 the resident care coordinator got a new menu from the kitchen manager with a date on it and hung it up on personal care.
On 7/11/2025 the resident care coordinator did a facility walk through to ensure that the menu was dated and in a conspicuous public place in the facility.
Starting on 9/1/2025 resident care coordinator weekly will check the menu at the beginning of the week to ensure that it is dated documentation will be kept.

Licensee's Proposed Overall Completion Date: *08/20/2025*

Implemented - 12/03/2025)

183b - Meds and Syringes Locked

23. Requirements

2600.
183.b. Prescription medications, OTC medications, CAM and syringes shall be kept in an area or container that is locked. This includes medications and syringes kept in the resident's room.

Description of Violation

On 7/8/25 at approximately 9:15 a.m., the medication cart containing medication for multiple residents, to include resident #1, was unlocked, unattended, and accessible in the hallway near bedroom #17 in the Secure Dementia Care Unit.

Plan of Correction ***Accept - 09/06/2025)***

On 7/8/2025 DCS immediately locked the medication cart.
On 7/11/2025 resident care coordinator did a walk through of the facility to ensure that medication carts were all locked during a non-med pass time.

183b - Meds and Syringes Locked (continued)

Starting on 9/1/2025 resident care coordinator [redacted] will check the medication carts on her shift during a non-med pass time to ensure that they are locked documentation will be kept.

Licensee's Proposed Overall Completion Date: *08/20/2025*

Not Implemented [redacted] - 12/03/2025)

184a - Resident's Meds Labeled

24. Requirements

2600.

184.a. The original container for prescription medications shall be labeled with a pharmacy label that includes the following:

1. The resident's name.
2. The name of the medication.
3. The date the prescription was issued.
4. The prescribed dosage and instructions for administration.
5. The name and title of the prescriber.

Description of Violation

Resident #1 is prescribed Tylenol, 325mg every 6 hours for pain. On 7/8/25, the pharmacy label on the medication indicated 3 times per day.

Resident #1 is prescribed Trazadone, 50mg at bedtime. On 7/8/25, the pharmacy label on the medication did not indicate the bedtime dosage.

Resident #7 is prescribed Docusate Sodium, 100mg capsule at bedtime. On 7/8/25, the pharmacy label on the medication indicated twice per day.

Resident #8 is prescribed Tylenol, every 6 hours as needed for pain. On 7/8/25, the pharmacy label on the medication indicated 1 per day.

Plan of Correction ***Accept ([redacted] - 09/06/2025)***

On 7/10/2025 the administrator [redacted] called pharmacy to double check what the prescriptions stated on their end. [redacted] went in and updated the MAR to show what the actual prescription instructions should be.
On 7/14/2025 the resident care coordinator [redacted] did a MAR/Cart audit to ensure that the changes to the MAR and the bottles were correct.
Starting on 8/1/2025 the med-techs do a weekly resident med cart audit on all the residents to ensure that the MAR, Prescriptions, and bottles are exactly what they should be documentation will be kept.

Licensee's Proposed Overall Completion Date: *08/20/2025*

Not Implemented ([redacted] - 12/03/2025)

187b - Date/Time of Medication Admin.

25. Requirements

2600.
187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

Resident #5 is prescribed Buspirone 5mg, take 1.5 tablets 3 times per day and Clonazepam 1mg, take 1 tablet 3 times per day. Resident #5's July 2025 Medication Administration Record did not include the initials of the staff person who administered these medications on 7/2/25 at 2:30 p.m.

Plan of Correction ***Accept [redacted] - 09/06/2025)***

On 7/10/2025 education was given by the administrator to the med tech that gave the medication on when and why initials need to be put on the MAR.
On 7/15/2025 education was given to all the med-tech by the administrator [redacted] on how to properly document on the MAR.
Starting on 8/1/2025 the resident care coordinator will audit the MAR daily to ensure that they are being documented on correctly. Weekly after a month and then monthly after that documentation will be kept.

Licensee's Proposed Overall Completion Date: *08/20/2025*

Implemented [redacted] - 12/03/2025)

187d - Follow Prescriber's Orders

26. Requirements

2600.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident #1 is prescribed Quetiapine, 50mg, take 1.5 tablets at 4:30 pm and at bedtime. However, this medication was not administered to resident #1 from 4:30 p.m. on 7/3/25 to 8:00 p.m. on 7/7/25 because the medication was not available in the home.

Resident #8 is prescribed Aspirin, 325mg tablet, take 1 tablet daily. However, this medication was not administered on 7/7/25, at 8:30 a.m. because the medication was not available in the home.

Repeat Violation: 10/1/2024

Plan of Correction ***Accept [redacted] - 09/06/2025)***

On 7/10/2025 the resident care coordinator ensured that the medications were ordered and that they were in the home.
On 7/15/2025 the administrator [redacted] gave education to all the med-techs on ordering medication in a timely manner and how to contact the pharmacy to get an emergency run to ensure that the medication is in the

187d - Follow Prescriber's Orders (continued)

home for all medication administration times.
Starting on 8/1/2025 the med-techs do a weekly resident med cart audit on all the residents to ensure that all the medications are in the home and that they are being ordered in a timely manor so they do not run out documentation will be kept.

Licensee's Proposed Overall Completion Date: *08/20/2025*

Not Implemented [redacted] - 12/03/2025)

190a - Completion Medication Course

27. Requirements

2600.
190.a. A staff person who has successfully completed a Department-approved medications administration course that includes the passing of the Department's performance-based competency test within the past 2 years may administer oral; topical; eye, nose and ear drop prescription medications and epinephrine injections for insect bites or other allergies.

Description of Violation

Staff person A, who has not successfully completed the Department-approved medications administration course, administered medications to multiple residents to include Levothyroxine 50mcg to resident #1 on 7/5/25 at 7:00 a.m.

Repeat Violation: 10/1/2024

Plan of Correction ***Accept [redacted] - 09/06/2025)***

On 7/10/2025 staff member A was pulled off of the medication cart, until 7/21/2025 when a train the trainer was able to come in and recertify [redacted] to pass medications.
On 7/16/2025 the resident care coordinator went through all of the med-techs certifications to ensure that they were all up to date.
Starting on 9/1/2025 the administrator [redacted] will audit all of the med-tech certifications quarterly to ensure that they are all up to date and upon a new med-tech being hired into the facility documentation will be kept.

Licensee's Proposed Overall Completion Date: *08/20/2025*

Not Implemented [redacted] - 12/03/2025)

191 - Resident Right to Refuse

28. Requirements

2600.
191. Resident Education - The home shall educate the resident of the right to question or refuse a medication if the resident believes there may be a medication error. Documentation of this resident education shall be kept.

Description of Violation

Resident #1, admitted [redacted]/25, has not been educated to the resident's right to refuse medication if the resident believes that there may be a medication error.

Repeat Violation: 10/1/2024

191 - Resident Right to Refuse (continued)

Plan of Correction ***Accept - 09/06/2025)***

On 7/10/2025 the administrator gave education to resident #1 on right to refuse medication.
On 7/17/2025 the administrator did an audit on all the contracts to ensure that all residents had been given education on their right to refuse medication.
Starting on 9/1/2025 the administrator will audit all current contracts quarterly to ensure that they are signed in completion and continue audits for all new residents that come into facility documentation will be kept.

Licensee's Proposed Overall Completion Date: *08/20/2025*

Not Implemented - 12/03/2025)

231c - Preadmission Screening

30. Requirements

2600.
231.c. A written cognitive preadmission screening completed in collaboration with a physician or a geriatric assessment team and documented on the Department's preadmission screening form shall be completed for each resident within 72 hours prior to admission to a secured dementia care unit.

Description of Violation

Resident #5 was admitted to the Secure Dementia Care Unit on 25; however, the resident's written cognitive preadmission screening, dated /25, does not indicate the needs of the resident require secured care due to Alzheimer's disease or other Dementia.

Repeat Violation: 10/1/2024, 7/23/2024

Plan of Correction ***Accept - 09/06/2025)***

On 7/9/2025 the box was marked and initialed and dated by the administrator to show that the resident indicated the need of a secured dementia unit.
On 7/10/2025 education was given to the resident care coordinator on the proper way to do the prescreen form.
Starting on 9/1/2025 the administrator will audit the prescreens to ensure that they are done properly and then audit them upon being done for a resident before admission.
By 9/1/2025 the administrator will audit written cognitive preadmission screenings for residents served in the SDU to ensure it indicated the needs of the resident requires SDC documentation will be kept.

Licensee's Proposed Overall Completion Date: *08/20/2025*

Not Implemented - 12/03/2025)

233c - Key-Locking Devices

31. Requirements

2600.
233.c. If key-locking devices, electronic cards systems or other devices that prevent immediate egress are used to lock and unlock exits, directions for their operation shall be conspicuously posted near the device.

233c - Key-Locking Devices *(continued)*

Description of Violation

On 7/8/25, the directions for operating the home's locking mechanism were not conspicuously posted near the following doors in the Secure Dementia Care Unit:
* *The main entrance door*
* *The emergency exit door next to bedroom #10*
* *The emergency exit door leading out of the facility through the courtyard gate*

Plan of Correction ***Accept [redacted] - 09/06/2025)***

On 7/10/2025 the administrator [redacted] posted the lock code near the the main entrance, and emergency exits.
On 7/15/2025 the administrator gave education to the staff on the importance of leaving these up where they are posted.
Starting on 9/1/2024 the DCS will check each shift to ensure that the code is still posted and document it on the shift duties sheet documentation will be kept.

Licensee's Proposed Overall Completion Date: *08/20/2025*

Not Implemented [redacted] - 12/03/2025)

Department of Human Services
Bureau of Human Service Licensing
LICENSING INSPECTION SUMMARY - PUBLIC

Facility Information

Name: *PENN HIGHLANDS JEFFERSON MANOR P. C.* **License #**: *40624* **License Expiration**: *10/11/2025*

Address: *417 RT. 28, BROOKVILLE, PA 15825*

County: *JEFFERSON* **Region**: *WESTERN*

Administrator

Name:

Legal Entity

Name: *JEFFCO HEALTH SERVICES INC*

Address: *417 RT. 28, BROOKVILLE, PA, 15825*

Phone:

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *02/09/1994* **Issued By**: *L&I*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *39* **Waking Staff**: *29*

Inspection Information

Type: *Partial* **Notice**: *Unannounced* **BHA Docket #**:

Reason: *Complaint* **Exit Conference Date**: *08/28/2025*

Inspection Dates and Department Representative

08/28/2025 - On-Site:

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *48* **Residents Served**: *24*

Secured Dementia Care Unit

In Home: *Yes* **Area**: *2nd* **Capacity**: *24* **Residents Served**: *15*

Hospice

Current Residents: *3*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *24*

Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *15* **Have Physical Disability**: *0*

Inspections / Reviews

08/28/2025 - Partial

Lead Inspector: **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *09/19/2025*

Inspections / Reviews *(continued)*

09/12/2025 - POC Submission

Submitted By: [redacted]
Date Submitted: *10/06/2025*
Reviewer: [redacted]
Follow-Up Type: *POC Submission*
Follow-Up Date: *09/19/2025*

09/15/2025 - POC Submission

Submitted By: [redacted]
Date Submitted: *10/06/2025*
Reviewer: [redacted]
Follow-Up Type: *Document Submission*
Follow-Up Date: *10/06/2025*

12/03/2025 - Document Submission

Submitted By: [redacted]
Date Submitted: *10/06/2025*
Reviewer: [redacted]
Follow-Up Type: *Enforcement*

187d - Follow Prescriber's Orders

3. Requirements

2600.
187.d. The home shall follow the directions of the prescriber.

Description of Violation

Resident #1 was prescribed Donepezil oral tablet 10mg, give one tablet by mouth at bedtime for Dementia. However, the medication was not administered to the resident on 8/9/25 and 8/10/25 because the medication was not available in the home.

Resident #3 was prescribed Metoprolol Succinate, give one tablet by mouth one time a day. Related to essential hypertension hold if blood pressure is less than 120/80. On multiple dates to include 8/10/25, 8/11/25, and 8/12/25, there were a blood pressure measurement of 115/77, 109/75, and 111/75 indicated on the resident's August 2025, Medication Administration Record. However, the medication was administered to the resident on the corresponding dates. Repeat Violation: 10/1/2024

Plan of Correction ***Directed - 09/15/2025)***

All staff will follow the directions of the prescriber. Administrator will reeducate staff on following prescribers' instructions. RCC will check monthly to ensure that staff are following the directions. re reeducated staff on how to reorder medications.

Proposed Overall Completion Date: 09/12/2025

Directed:
Within 7 days of receipt of the accepted plan of correction the administrator or designated staff person shall conduct a medication administration record audit to ensure medications are being administered as directed by the prescribing authority. Documentation of the training will be kept.
9/15/25
Directed:
Within 7 days of receipt of the accepted plan of correction, the administrator or designated staff person shall train all appropriate staff on regulation187d. Documentation will be kept.
. 9/15/25
Directed:
Within 7 days of receipt of the accepted plan of correction and for 16 weeks thereafter the administrator or designated staff person shall conduct weekly medication audits to ensure compliance with the regulation. Documentation will be kept.
. 9/15/25

Directed Completion Date: *09/12/2025*

Not Implemented - 12/03/2025)