STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396078	A. Building B. Wing	08/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Horsham Center for Jewish Life	1425 Horsham Road North Wales, PA 19454

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38947 Based on staff interviews, the review of the clinical record and facility documents, it was determined that the facility failed to ensure that the physician was notified regarding a resident's verbal threats of wanting to kill herself, and failed to ensure that the physician was notified when the resident reported to nursing staff that she ingested 25-30 milligrams of Tylenol for 1 out of 3 residents reviewed (Resident R1). Findings include: Review of the facility policy, Change in Condition, with a revision date of February 2021 indicted that the nurse will notify the resident's attending physician or physician on call for reasons that include, but not limited to the following: discovery of injuries of an unknown source; the refusal of treatment or medication two or more consecutive times, an accident or incident involving the resident and a significant change in a resident's physician/emotional/mental condition. Review of the policy also indicated that the resident's representative will also be notified. Review of the August 2024 physician orders for Resident R1 included hypertension (high blood pressure); chronic kidney disease (a gradual loss of kidney function that can lead to kidney failure); cerebral infarction (a stroke); muscle weakness; anxiety (excessive, persistent and uncontrollable worry and fear about everyday situations) and depression (a mood disorder that cause persistent feelings of sadness and loss of interest). Review of a nursing note dated August 3, 2022, at 10:20 p.m. by Licensed nurse, Employee E3 documented that while doing her rounds at the start of her shift (3:00 p.m. -11:00 p.m.), Resident R1 stated, I am going to kill myself. Licensed nurse, Employee E3 stated that she redirected the resident and the resident stated, know what to do and will do it. Licensed nurse, Employee E3 reported that she notified the supervisor, vitals were obtained, and she gave the report to the upcoming nurse for follow-up (11:00 p.m.-7:00 a.m.). (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of an interview conducted by the facility on August 6, 2024, with Licensed nurse, Employee E3 revealed that the resident told her that she wanted to kill herself because she was upset at the care she received Friday night related to having a bowel movement after drinking prune juice and the call bell response time. Licensed nurse, Employee E3 reported that she contacted the Nursing Supervisor, Employee E5 asking that the nurse assess the resident, but reported that nursing supervisor, Employee E5 never came to the floor. Licensed nurse, Employee E3's statement also indicated that when she completed her first medication administration on her shift, the resident's assigned nurse aide, Employee E6 came to the nurses station with a bottle of Tylenol. Nurse aide, Employee E6 told Licensed nurse, Employee E3 that the resident said that she took 25 pills. Licensed nurse, Employee E3 indicated in her statement that she called the Nursing Supervisor, Employee E5 by phone, did not get an answer, so she contacted the Unit Manager, Employee E7 and asked her what she should do. Licensed nurse, Employee E3 reported that the Unit Manager, Employee E7 told her to contact the nursing Supervisor, Employee E5. Licensed nurse, Employee E3 reported that the nursing supervisor came to the floor for the first time between 8:30 p.m. and 9:00 p.m. and instructed her to take vitals and keep an eye on her. Licensed nurse, Employee E3 reported that she checked on the resident frequently throughout her shift approximately every 25-30 minutes and that she thought that the resident should have a 1:1 instead. Licensed nurse, Employee E3 reported that she gave the resident her 9:30 p.m. medications and that the resident's assigned nurse aide checked on the resident throughout his shift. Employee E3 reported that the resident was asleep at 9:00 p.m. During an interview with Licensed nurse, Employee E3 on August 19, 2024, at 3:43 p.m. the statement that Employee E3 provided to facility administration on August 6, 2024 was reviewed with her, and she confirmed that it was an accurate account of what occurred. Employee E3 reported that the resident's assigned nurse aide for the 3:00 p.m. through the 11:00 p.m. nursing shift (Employee E6) also informed her (Employee E3) that when he went to conduct rounds at the beginning his shift, the resident also told him that she wanted to kill herself. Employee E3 notified the nursing supervisor, but he did not come up. Employee E3 reported that she also notified the licensed supervisor (Employee E5) when the assigned nurse aide (Employee E6) notified her that the resident reported that she took Tylenol. Review of a written nurse aide statement obtained during an interview conducted with Nurse aide, Employee E6 (assigned nurse aide for 3:00-11:00 p.m. shift) on August 6, 2024, indicated that the nurse aide reported that at the start of his shift at 3:00 p.m. the resident also told him that she wanted to kill herself because she was unhappy with the way that she is taken care of. The nurse aide reported that he notified licensed nurse, Employee E3 who then went to see the resident. The nurse aide reported that she told the nurse I am [AGE] years old. I don't know why I am still alive. The nurse aide reported that when he brought the resident her dinner tray she did not want to eat and stated that she wanted to kill herself. The nurse aide reported that he checked on her at approximately between 5:00 p.m. and 6:00 p.m. and that is when the resident told the nurse aide that she took 30 pills of Tylenol and showed the nurse aide the bottle which he brought to Licensed nurse, Employee E3. Continued review of the nurse aide's statement indicated that the nurse supervisor came to the floor later and took vital signs. The nurse aide, Employee E6 explained that he was not assigned to be a 1:1 for the resident but stated that he checked on her throughout his shift. Unit manager, Employee E7 (3:00 p.m. 11:00 p.m. shift) reported that Licensed nurse, Employee E3 contacted her at 5:43 p.m. on August 3, 2024, was frantic, and reported that the resident had suicidal ideations. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with Employee E7 on August 19, 2024 at 4:45 p.m. the statement that Employee E7 provided to facility administration on August 6, 2024 was reviewed with her, and she confirmed that it was an accurate account of what occurred. Review of a statement obtained from Nursing Supervisor, Employee E5 indicated that he came to see the resident, he did not notice any changes with the residents and that he took the resident's vitals. Nursing Supervisor, Employee E5 reported that he went to assess the resident around 5:00 p.m. regarding her behavioral threat and the resident told her that she wanted the police and that she was not happy. Nursing Supervisor, Employee E5 reported that he assessed the resident again at approximately 10:00 p.m. and that the resident did not tell him that she took medication to kill herself but told him that she wanted the police. The nurse supervisor reported that he instructed Licensed nurse, Employee E3 to monitor the resident and inform him of any changes. Review of an interview conducted with Licensed nurse, Employee E4 indicated that Employee E4 reported that at the start of her shift, she was notified by Licensed nurse, Employee E3 that the resident took Tylenol and that the bottle was taken from her room. Licensed nurse, Employee E4 reported that the resident told her that she took the pills before lunch and then told her that she took them at 6:00 p.m. Licensed nurse, Employee E4 also indicated in her statement that the resident reported that she was unhappy here and this is nowhere [sic} to live. Resident was transported to 911 and Licensed nurse, Employee E4 reported that she went into the resident room with the police present and the nurse supervisor for her shift present (Employee E8) and found another bottle of tylenol and eyedrops and removed them from the room. Continued review of the resident's clinical record and the investigation did not show evidence that the physician was contacted at any time during the 3:00 p.m. through the 11:00 p.m. nursing shift regarding the threats that that the resident verbalized to staff stating that she was going to kill herself, to ensure that the physician was notified of the change in mental status, and that any specific orders and/or instructions (e.g. instructions to send out to the hospital; instructions for the resident to have a 1:1; instructions to search the resident's room, etc) could be implemented by nursing staff to ensure appropriate care and services for the resident. Continued review of the clinical record and the investigation regarding the incident also did not show evidence that the physician was notified when the resident reported to staff that she ingested 25-500 mg of Tylenol, to ensure that the physician was notified of the resident's reported actions, and that any specific orders and/or instructions could also be implemented by nursing staff (e.g. send out to hospital; call poison control; monitor resident; search her room; refrain from administering any medication that she has scheduled for the evening, etc) to ensure appropriate care and services. During an interview with the Director of Nursing (DON) and the Nursing Home Administrator (NHA) on August 7, 2024 at 4:00 p.m. that there was no evidence that nursing staff during the 3:00 p.m. through the 11:00 p.m. shift notified the physician regarding the resident's initial threat of self-harm that she verbalized to nursing staff, and no evidence that nursing staff notified the physician when the resident reported to the nursing assistant on the 3:00 p.m. through the 11:00 p.m. that she ingested Tylenol. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Horsham Center for Jewish Life	1425 Horsham Road North Wales, PA 19454

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28 Pa Code 201.18 (b)(1) Management 28 Pa. Code 211.10 (c) Resident care policies 28 Pa. Code 211.12 (c)(d)(1)(3) Nursing services

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 38947 Based on interviews, review of clinical records, it was determined that the facility failed to ensure comprehensive person-centered plan of care for a resident with a history of passive suicidal ideation (thoughts of wanting to die or thinking one would be better off dead) for 1 out of 3 residents reviewed (Resident R1). Findngs include: Review of the facility policy, Care Plans, Comprehensive Person-Centered with a revision date of March 2022 indicated that assessments of residents are ongoing and care plans are revised as information about the resident and the resident's conditions change. Review of the August 2024 physician orders for Resident R1 included the diagnoses of hypertension (high blood pressure); chronic kidney disease (a gradual loss of kidney function that can lead to kidney failure); cerebral infarction (a stroke); muscle weakness; anxiety (excessive, persistent and uncontrollable worry and fear about everyday situations) and depression (a mood disorder that cause persistent feelings of sadness and loss of interest). Review of the resident's annual Minimum Data Set Assessment (MDS-a periodic assessment of a resident's needs) dated July 23, 2024 indicated that the resident was assessed with a BIMS (Brief Interview of Mental Status) score of 15, which indicated that the resident was cognitively intact. Review of a note written by the psychologist dated April 2, 2024, at 12:21 p.m. documented that the village leader (unit manager) called the psychologist and informed the psychologist that the resident left her (unit manager) several voicemails overnight reporting thoughts of being better off dead. The note also indicated that while meeting with the resident at the unit manager's request, the resident endorsed having felt overwhelmed with the thoughts of being better off dead last evening, but denied thoughts of self-harm then or in session. The psychologist reported that the resident stated that she was still having thoughts of being better off dead but denied suicide ideation. Review of a note written by the psychologist dated May 3, 2024, at 4:04 p.m. indicated a session with the psychologist where resident reported . thought of being better -off dead; she denied SI (suicidal ideation) on my interview . Review of a note written by the psychologists dated June 24, 2024, at 10:55 a.m. indicated a session with the psychologist .thoughts of being better off dead; she denied SI on my interview . Review of the resident's person-centered plan of care did not include any goals or interventions to address the resident's passive suicide ideations statements of being better off dead that would aide in preventing the resident from engaging in any self-harm behaviors. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Director of Nursing (DON) and Nursing Home Administrator (NHA) on August 8, 2024 at 5:30 p.m. it was discussed that there was no information in the clinical record to show evidence that a person-centered plan of care was developed for the resident's passive suicide ideation (thoughts of being better off dead) that was expressed on a number of occassions to the facility's psychologist and the facility's unit manager (Employee E7). 28 Pa Code 211.10(c) Resident care policies 28 Pa Code 211.10(d) Resident care policies 28 Pa Code 211.11(d) Resident care plan 28 Pa. Code 211.12(c(1))Nursing services 28 Pa. Code 211.12(d)(1) Nursing services 28 Pa. Code 211.12(d)(5) Nursing services

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38947 Based on staff interviews, review of facility policy, and review of the clinical record, it was determined that the facility failed to ensure that resident's medications were administered in a timely manner for 1 out of 3 residents reviewed (Resident R2). Findings include: Review of the facility policy, Administering Medications, with a revision date of April 2019, indicated that medication administration times are determined by resident need and benefit, not staff convenience, and includes the following factors that are considered: -enhancing optimal therapeutic effect of the medication -preventing potential medication or food interactions; and -honoring resident choices and preferences, consistent with his or her care plan Continued review of the facility policy indicated that medications are administered within one hour of their prescribed time, unless otherwise specified (for example, before and after meal orders). Review of the physician orders for Resident R2 indicated that the resident was admitted into the facility on [DATE] for rehabilitation services with diagnoses that included aftercare for knee replacement surgery; cataracts; dysphagia (difficulty swallowing) and Parkinson's disease (a progressive disorder that affects the nervous system and the parts of the body controlled by the nerves). The resident was subsequently discharged back to his home with his wife on August 1, 2024. Review of the resident's July 2024 physician orders indicted an order for Selegiline 1-5 milligram tablet, by mouth two times a day for the treatment of degenerative joint disease. The medication was ordered to be administered at 8:00 a.m. and 8:00 p.m. Review of the resident's Medication Administration Audit Report (a clinical time stamp on when medication was administered to a resident by nursing staff) for Selegilline, was reviewed for July 2024, indicated that the resident was administered the above referenced medication late on the following days: The resident's 8:00 a.m. dose for July 15, 2024 was administered at 10:03 a.m. The resident's 8:00 a.m. dose for July 17, 2024 was administered to the resident at 10:07 a.m. The resident's 8:00 a.m. dose for July 18, 2024 was administered to the resident at 10:19 a.m. The resident's 8:00 a.m. dose was administered to the resident at 10:01 a.m. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A physician's order starting upon the resident's admission instructed for the resident to be administered 1-25-100 milligram tablet of the medication, Carbidopa-Levodopa, by mouth four times a day for the treatment of Parkinson's Disease. The medication was ordered to be administered at 8:00 a.m. and 12:00 p. m. 4:00 p.m. and 8:00 p.m. Review of the resident's Medication Administration Audit Report was reviewed for July 2024 and indicated that the resident was administered the above referenced medication late on the following days: The resident's 8:00 a.m. dose was administered at 10:07 a.m. on July 17, 2024. The resident' s 12:00 p.m. dose was administered at 1:28 p.m. on July 17, 2024. The resident's 8:00 a.m. dose was administered at 10:19 a.m. on July 18, 2024. The resident's 8:00 a.m. dose was administered at 10:01 a.m. on July 20, 2024. A physician's order starting upon the resident's admission instructed for the resident to be administered 1-100 milligram tablet of the medication, Amantadine HCl Tablet, by mouth three times a day for the treatment of Parkinson's Disease. The medication was ordered to be administered at various times throughout the month of July 2024 due to orders being changed/adjusted. Review of the resident's Medication Administration Audit Report was reviewed for July 2024 and indicated that the resident was administered the above referenced medication late on the following days: The resident's 9:00 p.m. dose was administered at 11:02 p.m. on July 13, 2024 The resident's 8:00 a.m. dose was administered at 10:19 a.m. on July 18, 2024. The resident's 8:00 a.m. dose was administered at 10:01 a.m. on July 20, 2024. During a discussion with the Director of Nursing (DON) the Nursing Home Administrator (NHA) on August 8, 2024 at 3:30 p.m. the medications that were administered to the resident were reviewed with the DON. 28 Pa. Code 211.10(c) Resident care policies 28 Pa. Code 211.12(d)(1) Nursing services 28 Pa. Code 211.12(d)(1) Nursing services

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38947 Based on interviews, review of clinical records and facility documentation, it was determined that the facility failed to ensure that adequate supervision was provided to a resident who verbally expressed to nursing staff that she wanted to kill herself, which resulted in an Immediate jeopardy to Resident R1 who ingested acetaminophen, was transferred out to the hospital, had elevated blood levels of acetaminophen, and received treatment for intentional acetaminophen overdose (Resident R1). Findings include: Review of the August 2024 physician orders for Resident R1 included the diagnoses of hypertension (high blood pressure); chronic kidney disease (a gradual loss of kidney function that can lead to kidney failure); cerebral infarction (a stroke); muscle weakness; anxiety (excessive, persistent and uncontrollable worry and fear about everyday situations) and depression (a mood disorder that cause persistent feelings of sadness and loss of interest). Review of the resident's annual Minimum Data Set Assessment (MDS-a periodic assessment of a resident's needs) dated July 23, 2024 indicated that the resident was assessed with a BIMS (Brief Interview of Mental Status) score of 15, which indicated that the resident was cognitively intact. Review of a note written by the psychologist dated April 2, 2024, at 12:21 p.m. documented that the village leader (unit manager) called the psychologist and informed the psychologist that the resident left her (unit manager) several voicemails overnight reporting thoughts of being better off dead. The note also indicated that while meeting with the resident at the unit manager's request, the resident endorsed having felt overwhelmed with the thoughts of being better off dead last evening, but denied thoughts of self-harm then or in session. The psychologist reported that the resident stated that she was still having thoughts of being better off dead but denied suicide ideation. Review of a note written by the psychologist dated May 3, 2024, at 4:04 p.m. indicated a session with the psychologist where resident reported . thought of being better -off dead; she denied SI (suicidal ideation) on my interview . Review of a note written by the psychologists dated June 24, 2024, at 10:55 a.m. indicated a session with the psychologist .thoughts of being better off dead; she denied SI on my interview . Review of a nursing note dated August 3, 2022 at 10:20 p.m. by Licensed nurse, Employee E3 documented that while doing her rounds at the start of her shift (3:00 p.m. -11:00 p.m.), Resident R1 stated, I am going to kill myself. Licensed nurse, Employee E3 stated that she redirected the resident and the resident stated, know what to do and will do it. Licensed nurse, Employee E3 reported that she notified the supervisor, vitals were obtained, and she gave the report to the upcoming nurse for follow-up (11:00 p.m.-7:00 a.m.). (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of an interview conducted by the facilty on August 6, 2024, with Licensed nurse, Employee E3 revealed that the resident told her that she wanted to kill herself because she was upset at the care she received Friday night related to having a bowel movement after drinking prune juice and the call bell response time. Licensed nurse, Employee E3 reported that she contacted the Nursing Supervisor, Employee E5 asking that the nurse assess the resident, but reported that nursing supervisor, Employee E5 never came to the floor. Licensed nurse, Employee E3's statement also indicated that when she completed her first medication administration on her shift, the resident's assigned nurse aide, Employee E6 came to the nurses station with a bottle of Tylenol. Nurse aide, Employee E6 told Licensed nurse, Employee E3 that the resident said that she took 25 pills. Licensed nurse, Employee E3 indicated in her statement that she called the Nursing Supervisor, Employee E5 by phone, did not get an answer, so she contacted the Unit Manager, Employee E7 and asked her what she should do. Licensed nurse, Employee E3 reported that the Unit Manager, Employee E7 told her to contact the nursing Supervisor, Employee E5. Licensed nurse, Employee E3 reported that the nursing supervisor came to the floor for the first time between 8:30 p.m. and 9:00 p.m. and instructed her to take vitals and keep an eye on her. Licensed nurse, Employee E3 reported that she checked on the resident frequently throughout her shift approximately every 25-30 minutes and that she thought that the resident should have a 1:1 instead. Licensed nurse, Employee E3 reported that she gave the resident her 9:30 p.m. medications and that the resident's assigned nurse aide checked on the resident throughout his shift. Employee E3 reported that the resident was asleep at 9:00 p.m. During an interview with Licensed nurse, Employee E3 on August 19, 2024, at 3:43 p.m. the statement that Employee E3 provided to facility administration on August 6, 2024 was reviewed with her, and she confirmed that it was an accurate account of what occurred. Employee E3 reported that the resident's assigned nurse aide for the 3:00 p.m. through the 11:00 p.m. nursing shift (Employee E6) also informed her (Employee E3) that when he went to conduct rounds at the beginning his shift, the resident also told him that she wanted to kill herself. Employee E3 notified the nursing supervisor, but he did not come up. Employee E3 reported that she also notified the licensed supervisor (Employee E5) when the assigned nurse aide (Employee E6) notified her that the resident reported that she took Tylenol. Employee E3 reported that the nursing supervisor did not come up, so she called the Unit Manger (Employee E7) on day shift (7:00 a.m. through 3:00 p.m.) that the resident reported that she wanted to kill herself, and that the resident told her nurse aide (Employee E6) that she took 25 Tylenol, and that the nurse supervisor was notified, but he did not come to see the resident yet. Employee E3 reported that the Unit Manager told her to walk to the nurse supervisor's office to find him. Review of a written nurse aide statement obtained during an interview conducted with Nurse aide, Employee E6 (assigned nurse aide for 3:00-11:00 p.m. shift) on August 6, 2024, indicated that the nurse aide reported that at the start of his shift at 3:00 p.m. the resident also told him that she wanted to kill herself because she was unhappy with the way that she is taken care of. The nurse aide reported that he notified licensed nurse, Employee E3 who then went to see the resident. The nurse aide reported that she told the nurse I am [AGE] years old. I don't know why I am still alive. The nurse aide reported that when he brought the resident her dinner tray she did not want to eat and stated that she wanted to kill herself. The nurse aide reported that he checked on her at approximately between 5:00 p.m. and 6:00 p.m. and that is when the resident told the nurse aide that she took 30 pills of Tylenol and showed the nurse aide the bottle which he brought to Licensed nurse, Employee E3. Continued review of the nurse aide's statement indicated that the nurse supervisor came to the floor later and took vital signs. The nurse aide, Employee E6 explained that he was not assigned to be a 1:1 for the resident but stated that he checked on her throughout his shift. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with Employee E6 on August 19, 2024 at 12:04 p.m. the statement that Employee E6 provided to facility administration on August 6, 2024 was reviewed with him, and he confirmed that it was an accurate account of what occurred. Employee E6 also reported that the resident's statements about wanting to kill herself occurred during the beginning of his shift. He stated that he checked on her throughout his shift and that when he went to deliver the resident's dinner to her, she was lying in her bed. He reported that he was not told that the resident had to have a 1:1 (a staff member assigned to monitor a resident at all times due to medical or safety concerns.) Employee E6 reported that when he went back to the resident's room to retrieve her dinner tray, she told him that she did not want anything to eat and stated to him again that she wanted to kill herself. Unit manager, Employee E7 (3:00 p.m. 11:00 p.m. shift) reported that Licensed nurse, Employee E3 contacted her at 5:43 p.m. on August 3, 2024, was frantic, and reported that the resident had suicidal ideations. Unit manager, Employee E7 reported that she told Licensed nurse, Employee E3 to notify the nurse supervisor and that Licensed nurse, Employee E3 told her that the supervisor was not answering her phone. Unit manager, Employee E7 reported that she told Licensed nurse, Employee E3 to physically go try to locate the nurse supervisor. Unit manager, Employee E7 reported that she contacted Licensed nurse, Employee E3 at 6:37 p.m. and told her that the nurse supervisor came. During an interview with Employee E7 on August 19, 2024 at 4:45 p.m. the statement that Employee E7 provided to facility administration on August 6, 2024 was reviewed with her, and she confirmed that it was an accurate account of what occurred. Employee E7 reported that she was not working when she was contacted by Licensed nurse, Employee E3 and told Employee E3 to go physically find Employee E5 (nurse supervisor) since he had not coming up to the floor regarding what she reported to him regarding the resident stating that she wanted to kill herself and telling her assigned nurse aide that she took Tylenol. Review of a statement obtained from Nursing Supervisor, Employee E5 indicated that he came to see the resident, he did not notice any changes with the residents and that he took the resident's vitals. Nursing Supervisor, Employee E5 reported that he went to assess the resident around 5:00 p.m. regarding her behavioral threat and the resident told her that she wanted the police and that she was not happy. Nursing Supervisor, Employee E5 reported that he assessed the resident again at approximately 10:00 p.m. and that the resident did not tell him that she took medication to kill herself but told him that she wanted the police. The nurse supervisor reported that he instructed Licensed nurse, Employee E3 to monitor the resident and inform him of any changes. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	396078	A. Building B. Wing	08/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Horsham Center for Jewish Life	1425 Horsham Road North Wales, PA 19454

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of an interview conducted with Licensed nurse, Employee E4 indicated that Employee E4 reported that at the start of her shift, she was notified by Licensed nurse, Employee E3 that the resident took Tylenol and that the bottle was taken from her room. Licensed nurse, Employee E4 reported that Licensed nurse, Employee E3 told her that the nurse Supervisor, Employee E5 stated that she does not need a 1:1 but to monitor her every hour. Licensed nurse, Employee E4 reported that she questioned as to why the resident was not on a 1:1. Licensed nurse, Employee E4 reported that she checked on the resident and that she was sleeping when she received a call from the security office on the first floor informing her that the resident called 911 (Emergency Meidcal Services). Licensed nurse, Employee E4 reported that the resident told her that she took the pills before lunch and then told her that she took them at 6:00 p.m. Licensed nurse, Employee E4 also indicated in her statement that the resident reported that she was unhappy here and this is nowhere [sic} to live. Resident was transported to 911 and Licensed nurse, Employee E4 reported that she went into the resident room with the police present and the nurse supervisor for her shift present (Employee E8) and found another bottle of tylenol and eyedrops and removed them from the room. Review of a nursing note dated August 4, 2024 at 12:45 a.m. documented that the resident reported to Licensed nurse, Employee E4 (11:00 p.m. - 7:00 a.m.) that she called 911 because she took 25-500 milligram of Tylenol because she does not want to live here anymore. Licensed nurse, Employee E4 reported that 911 personnel transported the resident to the hospital and that Licensed nurse, Employee E4 left a voicemail message for the physician and contacted one of the resident's daughters. Review of an interview conducted with Nursing Supervisor, Employee E8 revealed that at the start of her shift she did not receive any information from the 3-11 p.m. nursing Supervisor, Employee E5 that the resident was having suicidal ideations. Nursing Supervisor, Employee E8 reported that the resident stated that she took 25 pills of Tylenol and told the Emergency Medical Technician and the police officer that she wanted to kill herself when she was assessed. Nursing Supervisor, Employee E8 reported that she told Licensed nurse, Employee E4 to search the resident's room for any other medications and that Licensed nurse, Employee E4 conducted the search and returned with a bag of medication that she found. Nursing Supervisor, Employee E8 was not available for interview with State Survey agency. Review of the resident's hospital records with the Director of Nursing on August 8, 2024 at 2:30 p.m. indicated that the resident's admitting diagnosis was intentional acetaminophen overdose and Cluster B personality disorders (a group of mental disorders that involve unpredictable dramatic or intensely emotional responses to things) and that the resident was treated with N-ACETYLCYSTEINE (also known as N-acetylcysteine (NAC), a medication that is used to treat paracetamol overdose, also known as acetaminophen overdose). Continued review of the hospital records indicated that the resident's acetaminophen level was 103.5 micrograms per milliliter (mcg/mL) of acetaminophen in her blood. A blood level of acetaminophen in the range of 10 to 20 mcg/mL is considered safe (Haldeman-Englert, Foley, [NAME], 2022). Review of the resident's clinical record did not show evidence that she was adequately supervised and interventions were implemented to ensure resident safety for a resident who verbally expressed to at least two facility staff that she wanted to kill herself, and then acted upon it by ingesting a large quantity of Tylenol pills. (continued on next page)

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	396078	A. Building B. Wing	08/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Horsham Center for Jewish Life	1425 Horsham Road North Wales, PA 19454

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview with the Director of Nursing (DON) and Nursing Home Administrator (NHA) on August 8, 2024 at 5:30 p.m. it was discussed that there was no information in the clinical record to show evidence that the resident was adequately supervised by staff to prevent self-harm. The facility failed to ensure that adequate monitoring and supervision was provided to a resident who expressed to nursing staff that she wanted to kill herself. The facility's failure to ensure that the resident received adequate monitoring and supervision resulted in the resident ingesting acetaminophen at the facility as an attempt to kill herself, being transferred out to the hospital, where she was assessed with an elevated blood level of acetaminophen, and received medical treatment for intentional acetaminophen overdose. Based on the above findings, an Immediate Jeopardy to the safety of the resident was identified to the Nursing Home Administrator (NHA) on August 19, 2024, at 10:53 a.m. for failure to adequately monitor and supervise a resident who verbally expressed to nursing staff that she had a desire to kill herself. An Immediate Jeopardy template (a document which included information necessary to establish each of the key components of immediate jeopardy) was provided to the Nursing Home Administrator and Director of Nursing on August 19, 2024, at 10:53 a.m. On August 19, 2024 at 3:18 p.m. the facility provided the following corrective action plan: 1. A facility sweep was completed to ensure that there is no medication in the rooms of residents who don't have a physician's order, or not approved for self-administration. 2. ROBO was made to all families on 8/4/2024 to remind them that if they are bringing in any medication for their loved ones, that they give it to the nurse's station to ensure that it is handled properly. 3. Touchdown (Closed Circuit TV) was updated on 8/4/2024 to add a message stating that medications must be received at the nurses' station and not directly to the resident's room. 4. All staff were educated on notifying the DON, NHA, and nursing supervisor that when a resident mention thought of self-harm and if medications are ever in a resident's room, they must notify the nurse supervisor to ensure that the resident has been approved to have the medications. Educations were completed for all staff working in the building on 8/5/2024. Ninety percent completion for overall staff was reached on 8/9/2024. 5. A minimum of 90% of licensed staff were in-serviced on immediately notifying the physician if a resident mentions thoughts of self-harm and to place the resident on 1:1 to ensure safety. 6. The policy regarding suicidal threats was updated to reflect any alarming language that might lead to potential suicide. All staff in the building will be educated today (8/19/24), or prior to coming in contact with any residents. 7. A random audit was conducted to ensure staff understood the above educations. These audits will continue weekly x 3 and monthly x 3. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	8. The facility will continue to conduct random audits of resident rooms to ensure that there are no medications in the rooms of residents who don't have a physician's order, or who are not approved for self-administration of medications. Theses audits will continue weekly x3 and monthly x3. 9. A whole house audit has been completed for all residents that triggered for suicidal ideations to ensure that all interventions are in place and care plans were updated. Audits will continue and will include new admissions, weekly x3 and monthly x3. 10. Audit results will be reviewed at QAPI X3 months. 11. Facility will educate residents who have a history of suicidal ideation/intent that incoming packages will need to be checked, with their permission, for any items that could potentially be used for self-harm. 12. Supervisor was suspended pending the investigation. Following verification of the implementation of the immediate action plan and review of staff education documentation, the Immediate Jeopardy was lifted on August 20, 2024, at 5:32 p.m. 28 Pa. Code 201.18(d) Management 28 Pa. Code 211.10(b) Resident care policies 28 Pa. Code 211.10(c) Resident care policies 28 Pa. Code 211.10(d) Resident care policies 28 Pa. Code 211.12(c) Nursing services 28 Pa. Code 211.12(d)(1) Nursing services 28 Pa. Code 211.12(d)(3) Nursing services 28 Pa. Code 211.12(d)(5) Nursing services 28 Pa. Code 211.11(a) Resident care plan

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38947 Based on a review of clinical records, facility documentation and interviews with staff, it was determined that the Nursing Home Administrator and the Director of Nursing failed to effectively manage the facility regarding the suicide attempt of one of three residents reviewed (Resident R1). Findings include: Review of the job description of the Nursing Home Administrator (NHA) indicated that the primary purpose of the job description is to manage the facility in accordance with current applicable federal, state, and local standards, guidelines and regulations that govern long term care facilities. Review of the job description of the Director of Nursing (DON) included organizing and directing administration, nursing services and resident care, in addition to developing, organizing, implementing and evaluating and directing the day-to-day functions of the Nursing Services Department, it programs and activities. Review of the August 2024 physician orders for Resident R1 included the diagnoses of hypertension (high blood pressure); chronic kidney disease (a gradual loss of kidney function that can lead to kidney failure); cerebral infarction (a stroke); muscle weakness; anxiety (excessive, persistent and uncontrollable worry and fear about everyday situations) and depression (a mood disorder that cause persistent feelings of sadness and loss of interest). Review of a nursing note dated August 3, 2022 at 10:20 p.m. by Licensed nurse, Employee E3 documented that while doing her rounds at the start of her shift (3:00 p.m. -11:00 p.m.), Resident R1 stated, I am going to kill myself. Licensed nurse, Employee E3 stated that she redirected the resident and the resident stated, know what to do and will do it. Licensed nurse, Employee E3 reported that she notified the supervisor, vitals were obtained, and she gave the report to the upcoming nurse for follow-up (11:00 p.m.-7:00 a.m.). Review of an interview conducted by the facility on August 6, 2024, with Licensed nurse, Employee E3 revealed that the resident told her that she wanted to kill herself because she was upset at the care she received Friday night related to having a bowel movement after drinking prune juice and the call bell response time. Licensed nurse, Employee E3 reported that she contacted the Nursing Supervisor, Employee E5 asking that the nurse assess the resident, but reported that nursing supervisor, Employee E5 never came to the floor. Licensed nurse, Employee E3's statement also indicated that when she completed her first medication administration on her shift, the resident's assigned nurse aide, Employee E6 came to the nurses station with a bottle of Tylenol. Nurse aide, Employee E6 told Licensed nurse, Employee E3 that the resident said that she took 25 pills. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with Licensed nurse, Employee E3 on August 19, 2024, at 3:43 p.m. the statement that Employee E3 provided to facility administration on August 6, 2024 was reviewed with her, and she confirmed that it was an accurate account of what occurred. Employee E3 reported that the resident's assigned nurse aide for the 3:00 p.m. through the 11:00 p.m. nursing shift (Employee E6) also informed her (Employee E3) that when he went to conduct rounds at the beginning his shift, the resident also told him that she wanted to kill herself. Employee E3 notified the nursing supervisor, but he did not come up. Employee E3 reported that she also notified the licensed supervisor (Employee E5) when the assigned nurse aide (Employee E6) notified her that the resident reported that she took Tylenol. Employee E3 reported that the nursing supervisor did not come up, so she called the Unit Manger (Employee E7) on day shift (7:00 a.m. through 3:00 p.m.) that the resident reported that she wanted to kill herself, and that the resident told her nurse aide (Employee E6) that she took 25 Tylenol, and that the nurse supervisor was notified, but he did not come to see the resident yet. Employee E3 reported that the Unit Manager told her to walk to the nurse supervisor's office to find him. Review of a written nurse aide statement obtained during an interview conducted with Nurse aide, Employee E6 (assigned nurse aide for 3:00-11:00 p.m. shift) on August 6, 2024, indicated that the nurse aide reported that at the start of his shift at 3:00 p.m. the resident also told him that she wanted to kill herself because she was unhappy with the way that she is taken care of. The nurse aide reported that he notified licensed nurse, Employee E3 who then went to see the resident. The nurse aide reported that she told the nurse I am [AGE] years old. I don't know why I am still alive. The nurse aide reported that when he brought the resident her dinner tray she did not want to eat and stated that she wanted to kill herself. The nurse aide reported that he checked on her at approximately between 5:00 p.m. and 6:00 p.m. and that is when the resident told the nurse aide that she took 30 pills of Tylenol and showed the nurse aide the bottle which he brought to Licensed nurse, Employee E3. Continued review of the nurse aide's statement indicated that the nurse supervisor came to the floor later and took vital signs. The nurse aide, Employee E6 explained that he was not assigned to be a 1:1 for the resident but stated that he checked on her throughout his shift. Unit manager, Employee E7 (3:00 p.m. 11:00 p.m. shift) reported that Licensed nurse, Employee E3 contacted her at 5:43 p.m. on August 3, 2024, was frantic, and reported that the resident had suicidal ideations. Unit manager, Employee E7 reported that she told Licensed nurse, Employee E3 to notify the nurse supervisor and that Licensed nurse, Employee E3 told her that the supervisor was not answering her phone. Unit manager, Employee E7 reported that she told Licensed nurse, Employee E3 to physically go try to locate the nurse supervisor. Unit manager, Employee E7 reported that she contacted Licensed nurse, Employee E3 at 6:37 p.m. and told her that the nurse supervisor came. (continued on next page)

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	396078	A. Building B. Wing	08/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Horsham Center for Jewish Life	1425 Horsham Road North Wales, PA 19454

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of an interview conducted with Licensed nurse, Employee E4 indicated that Employee E4 reported that at the start of her shift, she was notified by Licensed nurse, Employee E3 that the resident took Tylenol and that the bottle was taken from her room. Licensed nurse, Employee E4 reported that Licensed nurse, Employee E3 told her that the nurse Supervisor, Employee E5 stated that she does not need a 1:1 but to monitor her every hour. Licensed nurse, Employee E4 reported that she questioned as to why the resident was not on a 1:1. Licensed nurse, Employee E4 reported that she checked on the resident and that she was sleeping when she received a call from the security office on the first floor informing her that the resident called 911 (Emergency Medical Services). Licensed nurse, Employee E4 reported that the resident told her that she took the pills before lunch and then told her that she took them at 6:00 p.m. Licensed nurse, Employee E4 also indicated in her statement that the resident reported that she was unhappy here and this is nowhere [sic} to live. Resident was transported to 911 and Licensed nurse, Employee E4 reported that she went into the resident room with the police present and the nurse supervisor for her shift present (Employee E8) and found another bottle of tylenol and eyedrops and removed them from the room. Review of a nursing note dated August 4, 2024 at 12:45 a.m. documented that the resident reported to Licensed nurse, Employee E4 (11:00 p.m. - 7:00 a.m.) that she called 911 because she took 25-500 milligram of Tylenol because she does not want to live here anymore. Licensed nurse, Employee E4 reported that 911 personnel transported the resident to the hospital and that Licensed nurse, Employee E4 left a voicemail message for the physician and contacted one of the resident's daughters. Review of an interview conducted with Nursing Supervisor, Employee E8 revealed that at the start of her shift she did not receive any information from the 3-11 p.m. nursing Supervisor, Employee E5 that the resident was having suicidal ideations. Nursing Supervisor, Employee E8 reported that the resident stated that she took 25 pills of Tylenol and told the Emergency Medical Technician and the police officer that she wanted to kill herself when she was assessed. Nursing Supervisor, Employee E8 reported that she told Licensed nurse, Employee E4 to search the resident's room for any other medications and that Licensed nurse, Employee E4 conducted the search and returned with a bag of medication that she found. Based on the deficiencies identified in this report, the NHA and DON failed to fulfill essential duties and responsibilities of their position, contributing to the Immediate Jeopardy situation. Refer to F689. 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa Code 201.18(b)(1) Management 28 Pa. Code 201.18(b)(3) Management 28 Pa. Code 201.18(e)(1) Management

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 38947 Based on review of the clinical record and facility documentation, it was determined that the facility failed to ensure complete and accurate documentation related to a resident's mental health status for 1 out of 3 residents reviewed (Resident R1). Findings include: Review of the August 2024 physician orders for Resident R1 included the diagnoses of hypertension (high blood pressure); chronic kidney disease (a gradual loss of kidney function that can lead to kidney failure); cerebral infarction (a stroke); muscle weakness; anxiety (excessive, persistent and uncontrollable worry and fear about everyday situations) and depression (a mood disorder that cause persistent feelings of sadness and loss of interest). Review of the resident's annual Minimum Data Set Assessment (MDS-a periodic assessment of a resident's needs) dated July 23, 2024 indicated that the resident was assessed with a BIMS (Brief Interview of Mental Status) score of 15, which indicated that the resident was cognitively intact. Review of a note written by the psychologist dated April 2, 2024, at 12:21 p.m. documented that the village leader (unit manager) called the psychologist and informed the psychologist that the resident left her (unit manager) several voicemails overnight reporting thoughts of being better off dead. The note also indicated that while meeting with the resident at the unit manager's request, the resident endorsed having felt overwhelmed with the thoughts of being better off dead last evening, but denied thoughts of self-harm then or in session. The psychologist reported that the resident stated that she was still having thoughts of being better off dead but denied suicide ideation. Continued review of the multi-disciplinary notes did not show any documentation from the unit manager, Employee E7 related to the date that she received the voicemails when the resident left several voicemails overnight reporting thoughts of being better off dead, no documentation as to what specifically did the resident say in the voicemails, and what if anything was implemented by the unit manager after she listened to the voicemails. During an interview with unit manager , Employee E7 on August 20, 2024 at 11:33 a.m. she reported that she did not remember when the incident occurred, she reported that she did not write a note regarding the voicemails that the resident left, and that she did not remember exactly what the resident stated in the voicemails related to the resident having thoughts of being better of dead. Employee E7 reported that she just knows that she called the psychologist up and notified him about the voicemails that the resident left on the answering machine so that he could come in and see her. 28 Pa. Code 211.5 (f)(ii) Medical records 28 Pa. Code 211.12(c) Nursing services 28 Pa. Code 211.12(d)(1) Nursing services