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	01/08/2025

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 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** 41471 Based on the review of clinical records, facility documentation, facility policies, and interview with residents and staff, it was determined the facility failed to ensure a resident's environment was free of accident hazards, and failed to ensure hazardous materials were not accessible to one of nine residents (Resident R1). Staff failed to provide supervision for Resident R1 with documented history of suicidal ideation and who voiced suicidal thoughts. This failure resulted in Resident R1 obtaining a disposable razor and cutting her/his wrist. This failure placed Resident R1 at risk for serious injury and resulted in an Immediate Jeopardy situation for Resident R1. This deficiency is cited as past non-compliance. Findings Include: Review of facility policy Safety and Supervision of Residents dated August 2024, revealed Our facility strives to make the environment as free from accident hazards as possible. Resident safety, supervision and assistance to prevent accidents are facility-wide priorities. Safety risks and environmental hazards are identified on an ongoing basis through a combination of employee training, employee monitoring, and reporting processes; QAPI (Quality Assurance Improvement Plan) reviews of safety and incident/accident data; and a facility-wide commitment to safety at all levels of the organization. Individualized, Resident-Centered Approach to Safety 1. Our individualized, resident-centered approach to safety addresses safety and accident hazards for individual residents. 2. The interdisciplinary care team shall analyze information obtained from assessments and observations to identify any specific accident hazards or risks for individual residents. 3. The care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices. 4. Implementing interventions to reduce accident risks and hazards shall include the following: a. Communicating specific interventions to all relevant staff; (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	b. Assigning responsibility for carrying out interventions; c. Ensuring that interventions are implemented; and d. Documenting interventions. 1. Due to their complexity and scope, certain resident risk factors and environmental hazards are addressed in dedicated policies and procedures. These risk factors and environmental hazards include the following: a. Bed Safety; b. Safe Lifting and Movement of Residents; c. Falls; d. Smoking; e. Unsafe Wandering; f. Poison Control; g. Electrical Safety; and h. Water Temperatures. i. Items that can have potential harm Review of facility policy Suicide Threats dated August 2024, revealed that Resident suicide threats shall be taken seriously and addressed appropriately. 1. Staff shall report any resident threats or alarming passive language of potential suicide immediately to the nurse supervisor/charge nurse. 2. The nurse supervisor/charge nurse shall immediately assess the situation and shall notify the charge nurse/supervisor and/or director of nursing services of such threats. 3. After assessing the resident, the nurse supervisor/charge nurse shall notify the resident's attending physician and responsible party, and shall seek further direction from the physician. 4. All nursing personnel and other staff involved in caring for the resident shall be informed of the suicide threat and instructed to report changes in the resident's behavior immediately. 5. Staff will monitor the resident's mood and behavior and update care plans accordingly. 6. Staff shall document details of the situation objectively in the resident's medical record. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of facility policy 1:1 (a facility staff individually providing observation to a resident) Supervision of Residents dated December 31, 2024, revealed Resident safety is a priority at Horsham Center for Jewish Life. Residents that are exhibiting behaviors that may cause harm, are placed on 1 :1 supervision until IDT (Interdisciplinary team) team meets and updates plan of care to ensure safety. The behaviors below are not all inclusive: o Active/passive suicidal ideation o Repeated or continuing attempts to seriously self-harm o Active exit-seeking-residents o Repeated aggressive behaviors o Acute psychotic episodes. Once resident is placed on 1 :1 the following steps are to be followed: o Staff who is assigned will be given report on resident. o Shift to shift report will be completed when changing shift with ongoing and off going shift. o If any of the above behaviors arise, the supervisor is to be notified immediately. o One to one will always be within arm's length as it relates to resident safety. Review of Resident R1's clinical record revealed that the resident was admitted to the facility with diagnoses of bipolar disorder with psychotic episode (a mental illness that causes extreme mood swings, often called manic-depressive disorder), major depressive disorder (major loss of interest in pleasurable activites), and generalized anxiety disorder. Review of MDS (Minimum Data Set-Assessment of resident care needs) for Resident R1 dated December 3, 2024, revealed that the resident had a BIMS (Brief Interview for Mental Status) score of 13 which indicated that the cognitive status of the resident was intact. MDS mood assessment indicated that the resident felt down, depressed or hopeless 7-11 days in two weeks. Resident stated yes to Feeling bad about yourself - or that you are a failure or have let yourself or your family down, with a frequency of 2-6 days in 2 weeks. Resident also indicated feeling lonely or isolated. Review of care plan for Resident R1 dated August 11, 2024, revealed the resident had a history of suicidal ideation and/or intent. Care plan interventions included, assess for any suicidal ideations, consult psychology and/or psychiatry as ordered, If resident having active suicidal ideations check and remove any items/objects in room that could potentially be used for self-harm and place resident on 1:1, if needed. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of hospital record for Resident R1 dated December 24, 2024, revealed the resident admitted to the hospital from the facility for worsening depression. Resident continued to display symptoms of calling out, making statements of wanting to die and was referred for inpatient psychiatric stay. Review of physician's note for Resident R1 dated December 24,2024, revealed the resident had a recent stay at the hospital for uncontrolled anxiety and behaviors. Resident's diagnoses from hospital included depression, anxiety and bipolar disorder. The physician recommended to monitor resident closely. Review of nursing note for Resident R1 dated December 29, 2024, at 4:56 a.m., revealed the resident displayed signs of anxiety throughout the beginning of the shift. Review of nursing note for Resident R1 dated December 29, 2024, at 9:27 a.m., revealed that Nurse reports resident stated (she/he) is going to cut (his/her) wrists. 1:1 started, MD (physician) notified, VM (voice message) left for daughter, room searched for harmful objects. Resident is to have plastic silverware, dietary/nursing made aware. DON (Director of Nursing) notified. Review of nursing note for Resident R1 dated December 29, 2024, at 1:56 p.m., revealed the resident had signs and symptoms of anxiety. The resident was on 1:1 supervision for suicidal ideation. Resident to have plastic silverware. Resident displayed signs of anxiety throughout the shift. Review of facility investigation revealed a written statement provided by Employee E4, Registered Nurse, dated December 29, 2024 revealed the resident expressed that (he/she) wanted to cut (his/her) wrists. Resident was placed on 1:1. Employee E4 searched the tables, bathroom and the tray tables. Employee E4 removed scissors, pens, and a sharp rock painting off the wall. Review of physician progress note for Resident R1 dated December 30, 2024, revealed the practitioner recommended to continue 1:1 supervision for safety related to expressed concern. Review of Psychiatrist, Employee E8's note for Resident R1 dated December 30, 2024, revealed Continue 1:1 supervision for safety due to expressed concerns. Caution to discourage dependence on aide as secondary gain for attention in light of isolation. Review of facility investigation dated December 31, 2024, related to Resident R1 revealed Resident R1 had a vertical 1.5 inch scratch and three vertical 3 centimeters scratches medial to 1.5 inch. scratch to inner aspect of left wrist which occurred on December 31, 2024, around 5:40 a.m. Resident stated (he/she) attempted to cut (his/her) own wrist. Wound was cleaned with normal saline and covered with a dry dressing. Cleanse scratch on left wrist with normal saline and bacitracin applied then covered with Band-Aid until healed. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of nursing note for Resident R1 dated December 31, 2024, at 6:26 a.m., revealed, At approximately 0540 (5:40 a.m.) signee received a call from the Nurse Aide assigned to 1:1 explaining the resident acquired a razor and was threatening to cut her wrist. At the time of the call the CNA (nurse aide) didn't feel the resident would willingly relinquish the razor. Signee went to the resident's room to find she had given up the razor after she had scraped her wrist, causing a superficial abrasion. Wound was cleaned with NSS (normal saline solution) and covered with a clean dry dressing. Spoke with the resident to find she was feeling very down and lonely. Meanwhile the Nurse Aide swept the room for items the resident could potentially use to harm herself. Following our conversation . Mental Health Practitioner on-call contacted, message left requesting call-back. Physician called, message left requesting call-back; email sent reporting the incident. Strict 1:1 maintained. Report given to oncoming nurse and 1: 1 Nurse Aide. Review of nursing note for Resident R1 dated December 31, 2024, at 6:26 a.m., revealed While on unit A, passing morning medication. This nurse was notified by supervisor that resident had attempted to cut (his/her) wrist. Resident had several harmful items in (his/her) room upon searching by aide. After assessment, the resident received a superficial cut on the left inner wrist as 1: 1 aide was able to take item from resident. The supervisor notified the resident family as well as the psych nurse. Supervisor dressed resident cut. This nurse notified that resident will not go out at this time but will be seen by doctor. Items removed by aide. Resident complained of pain during this shift and received PRN (as needed) medication. Resident pleasant during this shift, however had moment of seeking excessive validation. Resident out of bed during most of this shift with 1 :1 aide in room. Resident plan of care is ongoing. Review of facility investigation revealed a written statement provided by statement from Licensed nurse, Employee E5, obtained by the Director of Nursing dated December 31, 2024, revealed that she confirmed the resident was on 1:1 during 11-7 with the resident. She stated that the resident was on precautions for norovirus (contagious virus that causes diarrhea and vomiting), and (he/she) was using the bathroom throughout the night into the early morning as (he/she) continued with gastrointestinal (GI) issues. Employee E5 stated that she gave the resident privacy in the bathroom and since (he/she) had norovirus while (he/she) was having ongoing GI issues. Staff remained outside the bathroom door Employee E5 stated that the resident came out of the bathroom and stated that (he/she) had cut (his/her) wrist with a razor that (he/she) found in the bathroom drawer. Immediately Employee E5 went into the bathroom to look in the drawer and she took a razor out of the drawer. She said that resident picked up the other razor and when Employee E5 asked for (resident) to give it to her Resident R1 declined. Employee E5 told (him/her) again that staff need to take the razor and if (resident) didn't give it to her, she would call security. The supervisor was called, and the resident handed over the razor. Review of progress note for Resident R1 by the Director of Nursing (DON) dated December 31, 2024, revealed that she assessed resident's left wrist, scratch marks are noted vertically on the inside of the wrist. Band-Aid was in place, some redness noted. Resident stated to the Director of Nursing, she/he did that with a razor that she/he found in the back of the bathroom drawer, and it was stupid of him/her to do, and regreted it. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with Employee E6, Licensed Practical Nurse, on January 7, 2025, at 11:50 a.m., revealed that she was working on December 29, 2024, when resident first expressed suicidal ideation. Resident told her that she/he was going to cut her/his wrist. Employee E6 stated the resident was placed on 1:1. Employee E6 stated 1:1 supervision should be provided all the time including inside the bathroom. Employee E6 stated razors were kept in locked clean utility room and she was not sure how resident obtained razors. Interview with Resident R1's husband who was a resident at the facility, on January 7, 2025, at 11:55 a.m., revealed that Resident R1 had severe depression since childhood. Husband stated the resident received the razors from the facility, it was the kind the facility provided. Interview with the Unit Manager, Employee E7 on January 7, 2025, at 12:00 p.m., stated she found potentially hazardous items during a search after resident cut her wrist. She stated the call bell cord was not removed after resident made the first threat, she had vaseline, lotions, and other personal product liquids in her room. Employee E7 stated resident told her that she/he got the razor from the bathroom drawer. Employee E7 stated razors should not be kept with residents with suicidal ideation and staff should stay at arms length of resident at all times when on 1:1 watch. Staff should have visual of resident even including the bathroom. Interview on January 7, 2025, at 1:00 p.m., with Employee E5, Nurse Aide who provided 1:1 supervision on December 31, 2024 to Resident R1 at the time that the resident cut her/his wrist stated that when she started 1:1 suicide watch shift, the aide I relieved informed me that the resident had been experiencing diarrhea. The resident remained awake throughout the night, frequently using the phone and going to the bathroom about every hour. At around 5:30 a.m., the resident came out of the bathroom and informed me that she/he had cut herself/himself while I was in her room. Resident R1 stated she/he had used a razor, and upon inspection, three disposable razors were found. The resident had stayed in her/his room all night, and the bathroom door had been closed during the resident use, preventing Employee E5 observing what the resident was doing in the bathroom. Employee E5 stated, she had assumed the resident had been searched before being placed on 1:1 observation. Staff stated she did not conduct a room sweep at the start of her shift. Employee E5 also stated she did not have proper PPE (Protective personal equipment), such as a mask, which limited her ability to provide supervision in the bathroom. Employee E5 stated she did not ensure the bathroom was safe before the resident used the bathroom and closed the door. After the incident, she conducted a room search and discovered a screwdriver and scissors in the desk drawer, two packs of thumbtacks in the drawer and some on the wall, two additional razors in the bathroom vanity drawer. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on January 7, 2025, at 1:40 p.m., with Employee E4, Registered Nurse, who searched resident room on December 29, 2024, when the resident expressed suicidal ideation stated she checked the bathroom, countertop, and drawers that was close to resident's bed, but didn't find anything. When asked if she thoroughly checked the bathroom vanity closet she stated I'm fairly certain I opened them fully, but nothing was removed from the bathroom. She stated she didn't search other cabinets and drawers other than the bedside table, where she only saw a pen and scissors. There was a sharp rock-like item on the wall which was removed. She stated she did not recall seeing a table or a cabinet next to the door. Employee E4 stated she didn't check other areas in the room, just the immediate area of the resident, and placed the resident on 1:1 supervision. Employee E4 stated the call bell cord was not removed as well. Employee E4 confirmed that the call bell cord should have been removed. Employee E4 stated resident was really anxious and a lot of time was spent calming the resident down. She stated she did not recall seeing any other items. Employee E4 also stated when residents were placed on 1:1, staff need to stay with the resident, keeping eyes on them at all times to monitor their actions. Interview with psychiatrist, Employee E8 on January 7, 2025, at 2:44 p.m. revealed that she ordered 1:1 supervision for safety related to suicidal ideation. Employee E8 stated due to resident's mental status she discouraged staff from providing companionship because she did not want resident to get used to it and to only use 1:1 for safety. Interview on January 7, 2025 at 1:40 p.m., with Employee E2, Director of Nursing, stated when resident who has a communicable disease is on isolation, staff should wear PPE and be with resident at all times. Staff should also thoroughly check the room for potentially dangerous objects when resident's express suicidal ideation. Director of Nursing confirmed that the staff did not thoroughly check Resident R1's environment when (he/she) expressed suicidal ideation on December 29, 2024, and did not provide 1:1 supervision consistently as ordered which resulted in resident obtaining razor and cut her wrist. An Immediate Jeopardy situation was identified to the Nursing Home Administrator on January 7, 2025, at 3:55 p.m. for the facility's failure to ensure that resident's environment was free of accident hazards, and failed to ensure that hazardous materials were not accessible to a resident. Staff failed to provide 1:1 supervision for Resident R1 with documented history of suicidal ideation and voiced suicidal thoughts two days prior to the indicent. This failure resulted in Resident R1 obtaining a disposable razor and cutting her/his wrist. The facility's failure placed Resident R1 who had a history of suicidal ideation at risk for serious injury and resulted in immediate jeopardy situation. An IJ Template was presented to the facility on [DATE], at 3:55 p.m. The facility submitted a written plan of action on January 7, 2024, at 6:10 p.m. and implemented the plan of action which included: Resident's room was searched for all potentially dangerous objects and were removed. Documentation revealed 1:1 supervision continued, December 31, 2024, and remains in place. Review of residents with SI (suicidal ideation) was conducted on December 31, 2024, no other residents on December 31, 2024, were being observed for SI. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility reviewed and implemented policies on December 31, 2024, to ensure that the residents with suicidal ideation/ behaviors that can lead to self-harm, do not have access to potentially dangerous objects such as sharp objects, medications, hazardous chemicals and staff provide appropriate 1:1 supervision when indicated. Education was started on December 31, 2024, for staff responsible for overseeing room searches on the policy of ensuring no sharp objects, medications, hazardous chemicals are accessible to the resident. December 31, 2024, achieving >77% and continued on January 1, 2025, with the facility completing >90%. Education will continue for any staff not educated, upon their return, prior to their 1:1 shift, until reaching 100%. Education was provided to staff providing 1:1 on ensuring that residents with SI are always within arm's length as per the supervision policy. Education was started on December 31, 2024, achieving >77% and continued on January 1, 2025, with the facility completing >90% and will continue upon their return for any staff not educated prior to their 1:1 shift until reaching 100%. Audit completed December 31, 2024, and continues Q (every) Shift for the resident on 1:1 for SI to ensure safe environment. QAPI meeting was conducted on December 31, 2024, with the IDT and will continue to be reviewed with the committee to determine if further action is needed. On January 8, 2024, at 4:45 p.m. the action plan was reviewed, observations were made of all nursing units and resident rooms. Interviews were conducted with staff to confirm that the in-service education was completed. Observation was completed to ensure consistent 1:1 observation was provided. Review of facility documentation revealed that the corrective plan was immediately developed and initiated on December 31, 2024. Audits were initiated to ensure that no sharp objects, medications, hazardous chemicals are accessible to the residents with suicidal ideation and residents with SI are always within arm's length as per the supervision policy. The facility reviewed and updated their policy related to 1:1 supervision. Additionally, the facility educated all staff to the updated facility policy. Interviews were conducted with Nurse Aides, Licensed nursing staff and Registered Nurses regarding trainings and competencies related to ensuring that no sharp objects, medications, hazardous chemicals are accessible to the residents with suicidal ideation and residents with SI are always within arm's length as per the supervision policy. Staff also stated that they received sufficient trainings from the facility. The facility alleged compliance with their plan of correction as of January 1, 2025. The Nursing Home Administrator was notified that the Immediate Jeopardy was lifted on January 8, 2025, at 4:45 p.m. This deficiency was identified as Immediate Jeopardy past non-compliance. 28 Pa. Code 211.12(d)(1) Nursing services (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	28 Pa. Code 211.12(d)(3)(5) Nursing services 28 Pa. Code 211.10(d) Resident care policies 28 Pa. Code 201.14(a) Responsibility of licensee 28 Pa. Code 211.18(b)(1) Management

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 41471 Based on review of facility records, job descriptions, and staff interviews, it was determined that the Nursing Home Administrator (NHA) and the Director of Nursing (DON) did not effectively manage the facility to ensure that the resident's environment was free of accident hazards, and failed to ensure hazardous materials were not accessible to a resident. This failure resulted in Resident R1 able to obtaining a disposable razor and cutting her/his wrist. The facility's failure placed Resident R1 who had a history of suicidal ideation at risk for serious injury and resulted in Immediate Jeopardy situation. Findings include: Review of the job description for the Nursing Home Administrator (NHA) revealed that The primary purpose of the job position is to manage the Facility in accordance with current applicable federal, state, and local standards, guidelines, and regulations that govern long-term care facilities. To follow all facility policies and apply them uniformly to all employees. To ensure the highest degree of quality care is provided to our residents at all times. As Administrator, you are delegated the authority, responsibility, and accountability necessary for carrying out your assigned duties. Every effort has been made to identify the essential functions of this position. However, it in no way states or implies that these are the only duties you will be required to perform. The omission of specific statement of duties does not exclude them from the position if the work is similar, related, or is an essential function of the position. Other related duties that may become necessary/appropriate to assure facility is in compliance with current laws, regulations, and guidelines concerning operation of facility. Supervise all department heads and administrative staff. Ensures a safe environment. Ensures that all incidents' or suspected incidents of resident abuse are investigated immediately and appropriate action is taken. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the job description for the Director of Nursing (DON) revealed that To plan, organize, develop and direct the overall operation of the Nursing Service Department in accordance with current federal, state, and local standards, guidelines, and regulations that govern the facility, and as may be directed by the Administrator and the Medical Director, to ensure that the highest degree of quality care is maintained at all times. As Director of Nursing, you are delegated the authority, responsibility, and accountability necessary for carrying out your assigned duties. Every effort has been made to identify the essential functions of this position. However, it in no way states or implies that these are the only duties you will be required to perform. The omission of specific statement of duties does not exclude them from the position if the work is similar, related, or is an essential function of the position. Organize and direct nursing administration, nursing services and resident care developing, organizing, implementing, evaluating and directing the day-to-day functions of the Nursing Service Department, its programs and activities. Participate in developing, maintaining and periodically updating written nursing policies, procedures, reference materials, manuals, objections, and philosophies. Is responsible for making daily rounds for observation of the care of residents, for talking with physician and visiting selected residents. Facilitates communication among employees, Supervisor, and instructors in all shifts to assess, plan implement, and evaluate resident related programs. Review nurse notes and monitor resident to determine if the care plans are being followed and if each resident's needs are being met, and, participate in assessing, reviewing and revising care plans as required. Review of Resident R1's clinical record revealed that the resident was admitted to the facility with diagnoses of bipolar disorder with psychotic episode (a mental illness that causes extreme mood swings, often called manic-depressive disorder), major depressive disorder, and generalized anxiety disorder. Review of MDS (Minimum Data Set-Assessment of resident care needs) for Resident R1 dated December 3, 2024, revealed that the resident had a BIMS (Brief Interview for Mental Status) score of 13 which indicated that the cognitive status of the resident was intact. MDS mood assessment indicated that the resident felt down, depressed or hopeless 7-11 days in two weeks. Resident stated yes to Feeling bad about yourself - or that you are a failure or have let yourself or your family down with a frequency of 2-6 days in 2 weeks. Resident also indicated feeling lonely or isolated. Review of care plan for Resident R1 dated August 11, 2024, revealed that the resident had a history of suicidal ideation and/or intent. Care plan interventions included, assess for any suicidal ideations, consult psychology and/or psychiatry as ordered, If resident having active suicidal ideations check and remove any items/objects in room that could potentially be used for self-harm and place resident on 1:1 (supervison), if needed. Review of facility investigation dated December 31, 2024, revealed that Resident R1 had a vertical 1.5 inch. scratch and three vertical 3 centimeters (cm) scratches medial to 1.5 inches scratch to inner aspect of left wrist which occurred on December 31, 2024, around 5:40 a.m. Resident stated she attempted to cut her/his own wrist. Wound was cleaned with normal saline and covered with a dean dry dressing. Cleanse scratch on left wrist with normal saline and bacitracin applied then covered with Band-Aid until healed. (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	01/08/2025

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.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of hospital record for Resident R1 dated December 24,2024, revealed that the resident admitted to the hospital from the facility for worsening depression. Resident continued to display symptoms of calling out, making statements of wanting to die and was referred for inpatient psychiatric stay. Review of physician progress note for Resident R1 dated December 24,2024, revealed that the resident recent stay at the hospital for uncontrolled anxiety and behaviors. Resident's diagnosis from hospital included depression, anxiety and bipolar disorder. Practitioner recommended to monitor resident closely. Review of nursing note for Resident R1 dated December 29, 2024, at 9:27 a.m., revealed that Nurse reports resident stated (she/he) is going to cut (his/her) wrists. 1:1 started, MD (physician) notified, VM (voice message) left for daughter, room searched for harmful objects. Resident is to have plastic silverware, dietary/nursing made aware. DON (Director of Nursing) notified. Review of nursing note for Resident R1 dated December 29, 2024, at 1:56 p.m., revealed that the resident was on 1: 1 supervision for suicidal ideation. Resident to have plastic silverware. Resident displayed signs of anxiety throughout the shift. Review of statement from Employee E4, Registered Nurse, dated December 29, 2024 revealed that the resident expressed that she/he wanted to cut her/his wrists. Resident was placed on 1:1. Employee E4 searched the tables, bathroom and the tray tables. Employee E4 removed scissors, pens, and a sharp rock painting off the wall. Review of physician note for Resident R1 dated December 30, 2024, revealed that the practitioner recommended to continue 1:1 supervision for safety related to expressed concern. Review of nursing note for Resident R1 dated December 31, 2024, at 6:26 a.m., revealed, At approximately 0540 (5:40 a.m.) signee received a call from the Nurse Aide assigned to 1:1 explaining the resident acquired a razor and was threatening to cut her wrist. At the time of the call the CNA (nurse aide) didn't feel the resident would willingly relinquish the razor. Signee went to the resident's room to find she had given up the razor after she had scraped her wrist, causing a superficial abrasion. Wound was cleaned with NSS (normal saline solution) and covered with a clean dry dressing. Spoke with the resident to find she was feeling very down and lonely. Meanwhile the Nurse Aide swept the room for items the resident could potentially use to harm herself. Following our conversation . Mental Health Practitioner on-call contacted, message left requesting call-back. Physician called, message left requesting call-back; email sent reporting the incident. Strict 1:1 maintained. Report given to oncoming nurse and 1: 1 Nurse Aide. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on January 7, 2025, at 1:00 p.m., with Employee E5, Nurse Aide who provided 1:1 supervision on December 31, 2024 to Resident R1 at the time that the resident cut her/his wrist stated that when she started 1:1 suicide watch shift, the aide I relieved informed me that the resident had been experiencing diarrhea. The resident remained awake throughout the night, frequently using the phone and going to the bathroom about every hour. At around 5:30 a.m., the resident came out of the bathroom and informed me that she/he had cut herself/himself while I was in her room. Resident R1 stated she/he had used a razor, and upon inspection, three disposable razors were found. The resident had stayed in her/his room all night, and the bathroom door had been closed during the resident use, preventing Employee E5 observing what the resident was doing in the bathroom. Employee E5 stated, she had assumed the resident had been searched before being placed on 1:1 observation. Staff stated she did not conduct a room sweep at the start of her shift. Employee E5 also stated she did not have proper PPE (Protective personal equipment), such as a mask, which limited her ability to provide supervision in the bathroom. Employee E5 stated she did not ensure the bathroom was safe before the resident used the bathroom and closed the door. After the incident, she conducted a room search and discovered a screwdriver and scissors in the desk drawer, two packs of thumbtacks in the drawer and some on the wall, two additional razors in the bathroom vanity drawer. Interview on January 7, 2025, at 1:40 p.m., with Employee E4, Registered Nurse, who searched resident room on December 29, 2024, when the resident expressed suicidal ideation stated she checked the bathroom, countertop, and drawers that was close to resident's bed, but didn't find anything. When asked if she thoroughly checked the bathroom vanity closet she stated I'm fairly certain I opened them fully, but nothing was removed from the bathroom. She stated she didn't search other cabinets and drawers other than the bedside table, where she only saw a pen and scissors. There was a sharp rock-like item on the wall which was removed. She stated she did not recall seeing a table or a cabinet next to the door. Employee E4 stated she didn't check other areas in the room, just the immediate area of the resident, and placed the resident on 1:1 supervision. Employee E4 stated the call bell cord was not removed as well. Employee E4 confirmed that the call bell cord should have been removed. Employee E4 stated resident was really anxious and a lot of time was spent calming the resident down. She stated she did not recall seeing any other items. Employee E4 stated when residents were placed on 1:1, staff need to stay with the resident, keeping eyes on them at all times to monitor their actions. Based on the deficiencies identified in this report, the Nursing Home Administrator and Director of Nursing failed to fulfill essential duties and responsibilities of their position to ensure that the Federal and State guidelines and Regulations were followed, contributing to the Immediate Jeopardy situation. Refer to F689 28 Pa. Code: 201.18(b)(1) Management 28 Pa. Code: 201.18(b)(3) Management