

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 396078	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/28/2025
NAME OF PROVIDER OR SUPPLIER Horsham Center for Jewish Life		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43923</p> <p>Based on clinical record review and staff interview, it was determined that the facility failed to make certain that the necessary resident information was communicated to the physician before the resident was discharged against medical advice (AMA) for one of one resident reviewed. (Residents R1).</p> <p>Findings include:</p> <p>Review of Resident R1's clinical record revealed the resident was admitted on [DATE], with the diagnoses of fracture of right lower leg, Parkinson's disease (movement disorder of the nervous system), dysphagia (difficulty swallowing), type 2 diabetes (failure of the body to produce insulin), and lack of coordination,.</p> <p>Review of Resident R1's Minimum Data Set (MDS - a periodic assessment of care needs) dated, November 16, 2024, revealed a Brief Interview for Mental Status (BIMS) of 15 which indicated that the resident was cognitively intact.</p> <p>On January 27, 2025, at 9:02 a.m., an interview was held with the Administrator, Employee E1, and the Director of Nursing, Employee E2, who reported that Resident R1 was discharged with AMA (Against Medical Advice) status as the family did not cooperate in receiving transfer training to safely take the resident to a funeral. The interdisciplinary team (IDT), did not agree with Resident R1 leaving the facility without the family being trained to safely transfer the resident.</p> <p>On January 27, 2025, at 10:42 a.m., a telephone interview was conducted with the physician (Employee E7). Employee E7 revealed that he/she was unaware of the AMA status or the family's non-compliance. Employee E7 received a message on January 16, 2025, requesting a call back before 10:00 a.m. regarding Resident R1. However, by the time the physician, Employee E7 returned the call, Resident R1 had already left the facility. Employee E7 stated during interview that if he/she had been informed, it would have been recommended that the facility document the family's refusal rather than having the resident sign for an Against Medical Advice (AMA) discharge.</p> <p>(continued on next page)</p>

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
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<p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On January 27, 2025, at 11:14 a.m., an interview was conducted with the Rehabilitation Director (Employee E6). Employee E6 revealed that on January 14, 2025, the family requested that Resident R1 attend a family funeral. Two male family members were designated to assist the resident with transfers, as the resident is unable to ambulate independently. Employee E6 reported that Resident R1 required one-person assistance with minimal support for transfers. The family was offered training the following day to ensure a safe transfer; however, the family declined, as the two family members were out of state and unavailable to attend the training.</p> <p>On February 27, 2025, at 12:00 p.m., an interview was conducted with the Director of Nursing (Employee E2) and the Administrator (Employee E1). Both employees confirmed that the physician was not informed about the status of Resident R1 before the resident left the facility, and they acknowledged that the physician should have been involved in the decision-making process.</p> <p>28 Pa. Code 201.29 (a)(c.3)(2) Resident rights</p>		

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<p>F 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or obtain dental services for each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43923</p> <p>Based on a review of clinical records and interview with resident and staff, it was determined that the facility did not ensure that routine dental services were provided to residents in a timely manner for one of five clinical records reviewed (Resident R1) .</p> <p>Findings include:</p> <p>Review of Resident R1's clinical record revealed the resident was admitted on [DATE].</p> <p>A review of the clinical record indicated that Resident R1 had a scheduled appointment on February 27, 2025, at 1:00 p.m. for the extraction of tooth #19. However, the prior dental consultation on February 13, 2025, indicated that R1's Xarelto medication needed to be held for three days before the scheduled procedure.</p> <p>A review of the Medication Administration Record (MAR) for February 23-27, 2025 revealed that Xarelto was administered, with no documentation indicating that it needed to be held for Resident R1 to undergo the scheduled procedure on February 27, 2025.</p> <p>On February 25, 2025, at 2:26 p.m., an interview with the unit manager, Employee E4 and the Director of Nursing (Employee E2) revealed that the Xarelto medication was not held prior to today's appointment due to the unit manager reported that she missed the special instruction to withhold it. As a result, the procedure needed to be rescheduled.</p> <p>28 Pa. Code 211.12 (d) (5) Nursing services</p>		

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<p>F 0840</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43923</p> <p>Based on interview with and review of clinical records, it was determined that the facility failed to ensure timely provision of professional services furnished by outside providers, for one of 5 residents reviewed (Residents R1).</p> <p>Findings include:</p> <p>Review of Resident R1's clinical record revealed the resident was admitted on [DATE], diagnosed with Fracture of Right lower leg, Parkinson's disease (movement disorder of the nervous system) and lack of coordination.</p> <p>Continued review of Resident R1's clinical record revealed that the resident sustained a fall on November 5, 2024, and was diagnosed with distal right fibula fracture. Resident R1 was receiving orthopedic services and had a follow up on December 23, 2024, with a recommendation for follow up in 4 weeks. Resident R1 next follow up appointment was scheduled for February 10, 2025, which resulted in a total of 8 weeks follow up.</p> <p>On February 27, 2025, at 2:26 p.m., an interview was conducted with the Director of Nursing, Employee E2 confirmed that Resident R1 had an appointment scheduled for January 20, 2025, which facility learned when the unit manager, Employee E5 who is no longer at the facility received a reminder email from the resident's family on January 19, 2025, reminding the facility about the upcoming appointment. However, transportation arrangements needed to be set up 48 hours in advance, and as a result, Resident R1's appointment had to be rescheduled.</p> <p>Further information revealed, according to an email dated on January 20, 2025, from the unit manager, Employee E5, it was stated: Summary notes were found in [Resident R1's] records this morning while passing medication. I asked the [Resident R1], upon her return, if she had a consultation sheet, to which she replied that she had given it to me.</p> <p>During this same interview Director of Nursing, Employee E2 confirmed that Employee E5 was terminated on February 13, 2025 due to unsatisfactory in regards to following up with families, residents.</p> <p>28 Pa. Code 211.12 (d)(1) Nursing Services.</p>