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	01/29/2026

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 - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on a review of facility policies, clinical records, and interviews with staff, it was determined that the facility failed to promptly inform the resident's representative of a significant change in the resident's condition and hospital transfer. This failure affected one of three residents reviewed (Resident R1).Review of the facility policy titled Change in a Resident's Condition or Status, dated February 2024, indicated that the facility is required to notify the resident and/or the resident's representative of any significant change in condition, including transfer to the hospital.Review of the resident's clinical record revealed that Resident R1 legally designated her family member as Power of Attorney, dated August 1, 2023.Review of the medical provider notes for Resident R1 dated January 9, 2025, at 9:31 a.m., documented: Patient seen and examined at request for changing condition. Aide reports noticing large amounts of blood on the floor, wheelchair, and bathroom floor. Upon immediate evaluation, patient resting in bed; gown covered with blood, dried blood on sheets, and large amount of blood on floor and wheelchair cushion. Patient awake, alert, appears weak and pale with some increased confusion. Noted rectal bleed. Reviewed with unit manager and agreed to transfer resident to the emergency room for further evaluation.Further review of the resident's clinical record revealed a nursing note authored by Licensed Nurse Employee E2 dated January 9, 2025, at 4:02 p.m., approximately six hours after the resident's noted change in condition and hospital transfer. The note stated the resident was sent to the hospital per medical provider instructions for rectal bleeding and transfer to the main hospital for gastrointestinal bleeding. The note further indicated that the niece was contacted at that time to provide an update and address questions and concerns.Interview with Licensed Nurse Unit Manager Employee E2 on January 29, 2025, at 1:30 p.m. revealed she was on duty on January 9, 2025, when she received notification of Resident R1's change in condition and need for emergency hospital transfer. Employee E2 stated she contacted emergency services and completed paperwork to accompany the resident to the hospital. Employee E2 reported that it is ultimately the bedside nurse's responsibility to notify the resident's family and assumed that Licensed Nurse Employee E3 had notified the resident's representative. Employee E2 confirmed it was not until later that afternoon-approximately five to six hours after the transfer-that she personally spoke with the resident's family member and confirmed the resident had been sent to the emergency room, at which time it was evident the representative had not been notified immediately.Interview with Licensed Nurse Employee E3 On January 29, 2025, at 2:00 p.m. confirmed she was on duty on January 9, 2025, and assigned to Resident R1. Employee E3 stated she was called to the resident's room by an aide due to concerns of large amounts of blood on the resident's bedding, gown, sheets, and floor. Upon arrival, the physician assistant was already assessing the resident, and a decision was made to transfer the resident to the hospital. Employee E3 acknowledged it was her responsibility to notify the resident's representative; however, she assumed the unit manager had completed the notification while making emergency calls and preparing transfer (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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(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 - Few	documentation. Employee E3 confirmed she did not verify that notification had occurred and was unaware the resident's representative had not been informed.Interview with the Nursing Home Administrator on January 29, 2026, at 1:10 p.m., confirmed there was a lapse in timely notification to the resident's representative regarding the resident's significant change in condition and hospital transfer. The administrator acknowledged a communication breakdown, citing a failure to clearly assign responsibility for notifying the resident's representative. 28 Pa. Code 201.29 (c.3)(2) Resident Rights28 Pa. Code 211.12 9(d)(1)(2)(3) Nursing Services