

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 03/21/2024
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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49736</p> <p>Based on clinical record review and review of facility policy, it was determined that the facility failed to ensure that the physician was notified of a resident change in condition related to abnormal blood sugar levels for one of 35 resident reviewed. (Resident R648)</p> <p>Findings include:</p> <p>Review of facilities policy titled Management of hypoglycemia revealed that the resident's provider was to be notify after giving the resident an oral form of rapidly absorbed glucose or glucagon.</p> <p>Review of Resident R648's clinical record revealed that the resident was admitted to the facility on [DATE] with the diagnoses of dementia (progressive degenerative disease of the brain) and type 1 diabetes (failure of the body to produce insulin to enable sugar to pass from the blood stream to cells) .</p> <p>Review of residents' care plan noted an intervention for resident's diagnosis of diabetes mellitus as monitor/document and report any signs or symptoms of hypoglycemia. Further review of residents' clinical record revealed special instructions to Please call Nurse Practitioner 1st with any changes in condition immediately after notifying MD.</p> <p>Review of resident's progress note on March 17, 2023 at 1:20 p.m revealed resident's blood sugar level was 61 and resident was 'feeling sick to her stomach'. Resident ate lunch and per progress note the resident's blood sugar level rose to 227 'an hour later' and 'insulin was administered. '</p> <p>Further review of blood sugar levels revealed resident's blood sugar level of 23 mg/dl on March 17, 2023 at 4:24 p.m.</p> <p>Review of Resident R648's Medication Administration Record (MAR) revealed Glucagon Emergency Kit 1mg administered in residents left deltoid. Progress note on March 17, 2024 at 4:53 p.m. revealed resident given food and drinks and 'supervisor was notified'.</p> <p>Further review of resident R648's clinical record revealed no documented evidence that the resident's physician was notified of the resident's blood sugar levels and the need to administer Glucagon on March 17, 2024.</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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>28 Pa Code 211.10(c) Resident care policies</p> <p>28 Pa. Code 211.12 (d)(1)(3) Nursing services</p>

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<p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p>46993</p> <p>Based on a review of clinical records, facility provided documentation, and interview with staff, it was determined that the facility failed to provide the required advanced notice, through a Notice of Medicare Non-Coverage (CMS 10123), regarding the termination of Medicare services for two of three residents sampled (Residents R141, R166)</p> <p>Findings include:</p> <p>The form Notice of Medicare Non-Coverage (NOMNC) CMS-10123, is a notice that informs the recipient when care received from the skilled nursing facility is ending; and how to contact a Quality Improvement Organization to appeal. The Medicare provider must ensure that the notice is delivered at least two calendar days before covered services end.</p> <p>Review of Resident R141's Notice of Medicare Non-Coverage (NOMNC) cms-10123 revealed that the Medicare skilled A services will end on December 11, 2023.</p> <p>Review of Resident R166's Notice of Medicare Non-Coverage (NOMNC) cms-10123 revealed that the Medicare skilled A services will end on December 14, 2023.</p> <p>Interview with the Nursing Home Administrator on March 21, 2024 confirmed the facility did not ensure to that notice was delivered at least two calendar days before Resident R141 and R166 covered services ended.</p> <p>28 Pa Code 201.29(a) Resident rights</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>49736</p> <p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>Based on review of clinical record review and interviews with staff, the facility failed to properly transcribe a physician order for one of four residents reviewed (Resident R105).</p> <p>Finding include:</p> <p>Review of Resident R105's clinical record revealed that the resident was admitted to hospice services with a diagnosis of systolic congestive heart failure (excessive body fluid caused by weakened heart muscle) on February 16, 2024. Included was a recommendation for Lorazepam 2mg/ml suspension with written instructions to take 0.5 mg (0.25ml) sublingual every 4 hours as needed for restlessness and anxiety. On February 17, 2024 the physician order was added with an end date 14 days later on March 2, 2024.</p> <p>Review of Resident R105's March 2024 physician orders revealed that the order was renewed on March 15, 2024 2024 and transcribed into the MAR incorrectly as scheduled every 4 hours. Resident received a dose on March 15, 2024 at 4:00 p.m and March 16, 2024 at midnight and 4:00 a.m. Progress note on March 16, 2024 at 2:57 p.m. revealed Lorazepam order was transcribed incorrectly. Order was discontinued.</p> <p>Interview with Director of Nursing on March 19, 2024 at 1:30 p.m. confirmed order was transcribed incorrectly and that they do not have a procedure for nurses on the floor when transcribing medications.</p> <p>28 Pa. Code 211.10 (c) Resident care policies</p> <p>28 Pa. Code 211.12 (d)(1) Nursing services</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>46106</p> <p>Based on observation, review of clinical records, and interviews with residents and staff, it was determined that the facility failed to maintain sufficient nursing staff levels to provide nursing care and services for three of 35 residents reviewed (Residents R135, R123 and R138).</p> <p>Findings include:</p> <p>Review of facility's policy Answering the Call Light revised September 2022, the purpose of this procedure is to ensure timely response to the resident's request and needs. Answer the resident call system within 5-15 minutes.</p> <p>An interview with Resident R135 on March 18, 2024, at 1:17 p.m. revealed that many times they must wait a long time to get change because they are short staff with nursing aides day and night shifts. Daily shift has two nurse aides and night shift has one nurse aide for 27 residents on D2 unit.</p> <p>An interview with Resident R123 on March 18, 2024, at 12:49 p.m. revealed that it a one hour waiting time to get your call bell answered because it one nurse aide only for 13 residents.</p> <p>An interview with Registered Nurse, unit manger, Employee E16, on March 18, 2024, at 1:20 p.m. provided nurse aides daily assignment sheet and it revealed two nursing aides on each unit D2 and C2. Also, it was reported that they always had it this way.</p> <p>An interview with Resident R138 on March 19, 2024, at 11:30 a.m. revealed and observed that still need to get washed and dressed.</p> <p>Observations on March 19, 2024, at 10:00 a.m., on second floor, unit C, revealed that many residents reported that only two nurse aides for one unit. Residents were still waiting to be provide morning hygiene care and dressed.</p> <p>Observations on March 19, 2024, 11:30 a.m. on the second floor, C unit revealed residents still waiting to be provide morning bed bath hygiene care. Three call bells were observed on. The call bell was answered and turn off by Licensed nurse, Employee E15 on March 19, 2024 at 11:44 a.m. Employee E15 informed the residents that their nurse aide will come in soon.</p> <p>Observations on March 19, 2024, at 11:35 a.m. revealed that Resident R138 was still in her hospital gown and waiting to receive assistance to use the bathroom and get morning care.</p> <p>Observations on March 19, 2024, at 11:45 a.m., on second floor unit C, revealed a number of residents who were still waiting to be changed and washed up from the night.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview with the nurse aide, Employee E12, on March 19, 2024, at approximately 10:35 a.m. revealed that there were two nursing aides for 27 residents on C2 unit. Also reported that they were behind on resident's care because of being short staff. Also, many time they can't do resident's care or answer call bells in a timely manner because of only two nursing aides on the unit. Also, it was reported that nursing aides don't have time to take they breaks or lunch because it is a lot of work with 13 residents on their case load or other nursing aide needs to help with two-person assistant.</p> <p>Resident council was held on March 20, 2024, at 10:30 a.m. with alert and oriented residents (Residents R79, R41, R201, R95, R259, R89, R123 and R130) revealed that short staff with nurse aide. Residents reported that they must wait up to an 1 hour or longer to get ready or washed up because its only two nurse aide working on each unit.</p> <p>An interview with Register Nurse, unit manger Employee E16, on March 19, 2024, at approximately 2:01 p. m. revealed and confirmed that they have two nurses aides per unit for D2 unit for 27 residents and C2 unit 26 residents.</p> <p>28 Pa Code: 211.12 (d)(4) Nursing services</p> <p>28 Pa Code: 201.14(a) Responsibility of licensee</p>		

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<p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Post nurse staffing information every day.</p> <p>46993</p> <p>Based on observations and interview with staff, it was determined that the facility did not ensure to post nurse staffing data on a daily basis in a prominent place as required and did not provide form in a clear and understandable format.</p> <p>Findings include:</p> <p>Observations on March 18, 2024 at 1:00 p.m. of the main lobby revealed Daily staffing for Monday march 18, 2024, unit: default, census .1.</p> <p>Review of Daily Staffing for March 12, 2024 through March 18, 2024 revealed no evidence of correct census, no minimum working hours required for RN's, LPN's and nurse aides, no evidence of actual hours worked and no documentation of call outs.</p> <p>Observation of units A2, B2 and D3 on March 18, 2024 through March 21, 2024 revealed no evidence of nursing staff data.</p> <p>Interview with facility's executive director, staffing coordinator, as well as administrator on March 18, 2024 and March 21, 2024 confirmed that daily staffing format was incorrectly filled out and not placed in a prominent place for residents to access.</p> <p>28 Pa Code 201.14(a) Responsibility of licensee</p>

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<p>F 0802</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service.</p> <p>29720</p> <p>Based on observation and interviews with staff and residents, it was determined that the facility did not employ sufficient staff to carry out the functions of food and nutrition services and that meals were served timely in one of three dining rooms (Second floor).</p> <p>Findings include:</p> <p>Observation of lunch meal service on March 18, 2024 at 12:15 p.m. revealed eighteen residents seated in the dining room waiting for lunch. All residents were offered a beverage. At 12:30 p.m., Food Service staff, Employee E17 pushed a cart into the dining room with eight bowls of soup. Seven residents were seated at a table and only one resident received a bowl of soup. At 12:45 p.m., Employee E17 pushed in a cart of eight more bowls of soup. At 12:55 p.m. the final resident received a bowl of soup. Resident R134 stated the soup is not hot. Employee E17, picked up the bowl of soup and went into the pantry where she reheated the soup in the microwave. She brought the soup out to Resident R134 who stated, yes, the soup was hot It's fine. Again, Employee E117 came from the pantry with eight entrees and only one resident at the table of seven was served. Ten minutes later, Employee E17 returned with eight more entrees. Resident R134 stated, I am always last. At this time, residents were leaving the dining room without being offered chocolate parfait, the dessert listed on the menu.</p> <p>An interview on March 18, 2024 at 1:10 p.m. with Employee E17 revealed that his job title was food service worker and he was responsible for delivering food from the pantry to the residents seated in the dining room.</p> <p>An interview on March 18, 2024 at 1:15 p.m. with Employee E4, Registered Dietician, revealed that the food temperatures were not taken for food items on the steamtable in the pantry which was located adjacent to the dining room. Employee E4 located the food thermometer and stated that food should have been temped at point of service but the food arrived late. Employee E4 confirmed that Employee E10 should not have microwaved the soup and that soup should have been temped before serving to residents.</p> <p>An interview on March 18, 2024 at 1:20 p.m. with Employee E10 revealed that her job title was Dining Concierge. The Job Overview revealed that the dining concierge is responsible for assisting the dietary department with the menu process and meeting with residents to assist with their meal selections. The dining concierge provides an overview of the meal selection process to new admissions and those who call with inquiries. The dining concierge is a hospitality professional who attends to the needs of patients/residents and helps them with the menu/meal selection process while staying at the skilled nursing facility. Interview with Employee E17 confirmed that Dining Concierge job description did not include reheating food in the microwave.</p> <p>An interview on March 18, 2024 at 2:45 p.m. with Nursing Home Administrator revealed, lunch arrived late due to not having enough staff in the dietary department due to call outs.</p> <p>28 Pa. Code 201.18 (b)(3) Management</p> <p>(continued on next page)</p>		

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa Code 211.6(c)(d)(1) Dietary Services

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>46106</p> <p>Based on observations of the Food and Nutrition Services, reviews of policies and procedures and food committee meeting minutes, and interviews with residents, it was determined that the facility failed to ensure that each resident received foods and beverages that were palatable and at safe and appetizing temperatures for five of 35 residents reviewed (Residents R123, R11, R134, R135 and R69) and in two of six nursing units. (D2 second floor, and B2 second floor</p> <p>Findings include:</p> <p>A review of facility documentation titled HACCP Daily Tasty Panel Chart log on March 21, 2024, stated that recommended serving temperatures to ensures hot or cold food at of consumption: soup, sauces, gravies, vegetables 160 degrees Fahrenheit (F) to 180 degrees Fahrenheit (F), meat, poultry, seafood and eggs 145 degrees Fahrenheit (F) to 165 degrees Fahrenheit (F), and cold food below 40 degrees Fahrenheit (F) and other entrees 160 degrees Fahrenheit (F). A review of facility policy title Food Holding Temperature Requirements: states that food temperatures should be taken prior to service to ensure that holding temperatures.</p> <p>Interview on unit D2 dining room with Resident R123 on March 19, 2024, at 12:29 p.m. revealed that most of the time food is not hot and a lot of carbs.</p> <p>Interview on unit D2 dining room with Resident R111 on March 19, 2024, at 1:02 p.m. revealed that grill sandwich was just delivered to her room, and it was cold.</p> <p>Interview on unit D2 dining room with Resident R134 on March 19, 2024, at 1:23 p.m. revealed that food served cold and a lot of sandwiches.</p> <p>Interview on unit D2 dining room with Resident R135 on March 19, 2024, at 1:23 p.m. revealed that food sometimes comes undercooked or overcooked, cold and needs to be reheated in the microwave.</p> <p>Interview on unit C1 dining room with Resident R69 on March 21, 2024, at 2 p.m. revealed that food preference are not honored.</p> <p>Resident council was held on March 20, 2024, at 10:30 with alert and oriented residents (Residents R79, R41, R201, R95, R259, R89, R123 and R130) revealed that these residents were unsatisfied with the food temperature.</p> <p>During lunch time observation on March 21, 2024, at 12:00 p.m. in unit D2 second floor in the small unit kitchen it was revealed that food was getting served on resident's plates without taking the temperature of each hot food in the steam table.</p> <p>During lunch time observation on March 21, 2024, at 12:19 p.m. in unit B2 second floor in the small unit kitchen it was revealed that food was getting served to the resident's plates without taking the temperature of each hot food on the steam table. Also, the food was plated without lids and plate covers to keep the appropriate food temperature.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Food Service staff, Employee E13 confirmed that they didn't take temperature the food prior serving. Also, food service employee E 13, started to microwave food that was plated and sitting out without plate covers and also didn't take the temperature after heating the food.</p> <p>Temperatures of the food were taken on March 21, 2024 at 12:23 p.m. with food service staff, Employee E13 and Food Manager, Employee E14 revealed that eggplant was 172 degrees Fahrenheit (F), Pasta was 152 and low sodium pasta was 119 degrees Fahrenheit (F), soup was 136 degrees Fahrenheit (F), stuffed pepper was 154 degrees Fahrenheit (F) and grill cheese sandwiched was 124 degrees Fahrenheit (F).</p> <p>Food Manager took the pasta, grilled cheese sandwiches and soup to big kitchen to be reheated. Also confirmed that it was not the right temperature, that they follow from the HACCP Daily Tasty Panel Chart log. Unit B2 small kitchen staff didn't wait for the reheated food to come back from the kitchen and started to serviced food with not appropriate food temperature and send out the open food chart to resident's rooms at 12:46 p.m</p> <p>A test tray was completed on the second floor on unit B2 resident's rooms with Food Manager, Employee E14 at 12:47 p.m. it was revealed that pasta was 118 degrees Fahrenheit.</p> <p>An interview with the Food Manager, Employee E14, on March 21, 2024, at approximately 12:50 p.m. confirmed that the above-mentioned food items were below the acceptable temperatures, and it shouldn't being send out and served to the residents in their rooms.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code 201.18 (b)(3) Management</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36609</p> <p>Based on review of clinical records and interviews with staff, it was determined that the facility did not ensure residents' medical records were complete and accurately documented for one of 35 resident records reviewed (Resident R199).</p> <p>Findings include:</p> <p>Resident R199 was admitted to the facility on [DATE], with diagnoses of high blood pressure, depression, and chronic kidney disease.</p> <p>Review of 199's Living Will explained that the document lets the person express their wishes about life support and allows them to appoint someone to speak on their behalf when they cannot speak for themselves, in the event they become terminally ill. The documentation states the declaration must be signed including month and date, by the resident or have another person sign on their behalf and, also in the presence of at least two individuals. Further review of Resident R199 living will revealed the resident failed to specify the year it was signed and did not include the signatures of two people as witnesses.</p> <p>Interview with the Director of Nursing on March 20, 2024, at 1:30 p.m. stated Resident R199's living will was not valid due to missing signatures and incomplete date.</p> <p>28 Pa. Code 211.12(d)(5) Nursing services</p>		