

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 06/20/2025
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 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.</p> <p>Based on observations; review of clinical records, policies, and procedures; and staff interviews; it was determined that the facility failed to ensure that a resident was free from physical restraints for one out of 35 residents reviewed (Resident R156).</p> <p>Findings include:</p> <p>Review of Resident R156's clinical record revealed that the resident was admitted in the facility on June 1, 2024, with diagnoses including Unspecified Dementia, Unspecified Severity, Without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, and Anxiety (Dementia is the loss of cognitive functioning - thinking, remembering, and reasoning - to such an extent that it interferes with a person's daily life and activities), Parkinson's Disease with Dyskinesia (neurological disorder that primarily affects movement, causing symptoms like tremors, stiffness, and slowness of movement), Anxiety Disorder (Anxiety disorders are a group of mental health conditions characterized by excessive, persistent, and uncontrollable feelings of worry and fear), and Depression (major loss of interest in pleasurable activities).</p> <p>Review of Resident R156's physician orders revealed an order, dated October 25, 2024, to check placement of bed alarm for placement and function every shift for safety.</p> <p>Review of Resident R156's care plan, revealed; Chair alarm in place, date-initiated April 18, 2025, and Bed Alarm in place while in bed. Check for proper function daily, date-initiated July 2, 2024.</p> <p>Review of Resident R56's Minimum Data Set (MDS- assessment of resident care needs) dated May 6, 2025, indicated that bed alarm and chair alarm were used daily. Continued review of the MDS revealed that the resident was assessed as requiring partial to moderate assistance for sit to lying in bed, sit to stand and for lying to sitting on side of bed.</p> <p>Observation conducted on June 17, 2025, at 12: 36 p.m., revealed that Resident R156's has a bed alarm in placed.</p> <p>Review of Resident R156's clinical records of Resident R156 revealed no documented evidence that the resident was evaluated for the use of a chair/bed alarm.</p> <p>Interview with Employee E6, the Unit Manager, a Registered Nurse, on June 17, 2025, at 12:39 p.m., confirmed the findings.</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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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28 Pa Code 211.8(f) Use of restraints

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>Based on observations, review of facility policies, clinical record reviews and interviews with staff, it was determined that the facility failed to ensure appropriate enteral feeding practices related to labeling for one of two residents reviewed for tube feeding (Resident R299).</p> <p>Findings include:</p> <p>Review of physician order for Resident R299, dated April 27, 2025, indicated, one time a day Administer Jevity 1.5 @50 ml/hr until total volume of 500 ml daily has infused .</p> <p>Observations on June 18, 2025, at 1:37 p.m. in Resident R299's room, revealed that the bottle of Jevity 1.5 Enteral Feed was dated June 10, 2025.</p> <p>Follow-up interview with the unit manager, Employee E11 at 1:39 p.m. confirmed the above-mentioned finding. Continued interview revealed that the enteral feed bottle must be discarded every 24 hours.</p> <p>28 Pa Code 211.10(c) Resident care policies</p> <p>28 Pa Code 211.12(d)(3)(5) Nursing services</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>Based on observed, clinical record review and staff interview, it was determined that the facility failed to provide appropriate respiratory care and services for one of 35 residents reviewed (R205).</p> <p>Findings include:</p> <p>Review of physician order for Resident R205 indicated an order dated March 9, 2025; Check and change Oxygen tubing weekly and as needed, every night shift, every Saturday per protocol; date the Oxygen tubing.</p> <p>Review of physician order for Resident R205 indicated an order dated May 8, 2025; Oxygen at two Litters, to keep SPO2 (pulse oxygen level) greater than 90, Every Shift for Shortness of Breath.</p> <p>Observation conducted on June 17, 2025, at 10:37 a.m., revealed that Resident R205 was disconnected from Oxygen tube, although the Oxygen Concentrator was running, and while the oxygen tubing was laying on the floor.</p> <p>At the time of the finding the same was confirmed with a Licensed Nurse, Employee E7.</p> <p>28 Pa Code 211.10(c) Resident care policies</p> <p>28 Pa Code 211.12(d)(5) Nursing services</p>

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<p>F 0699</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care or services that was trauma informed and/or culturally competent.</p> <p>Based on review of clinical records, staff and resident interviews, it was determined that the facility failed to provide culturally competent, trauma care in accordance with professional standards of practice, accounting for the resident's past experiences and preferences in order to eliminate and/or mitigate triggers that may cause re-traumatization of the resident for one of three residents sampled for behavior. (Resident R130)</p> <p>Findings include:</p> <p>A review of the clinical record revealed that Resident R130 was admitted to the facility, with diagnoses to include post-traumatic stress disorder (PTSD)(a mental health condition that develops after experiencing or witnessing a traumatic event, such as a natural disaster, war, violent crime, or personal loss), anxiety disorder, and bipolar disorder.</p> <p>A quarterly Minimum Data Set assessment (MDS- a federally mandated standardized assessment process conducted at specific intervals to plan resident care) for Resident R130 dated April 8, 2025, Section I, Active Diagnoses, Psychiatric/Mood Disorder, question I6100, indicated the resident has post-traumatic stress disorder (PTSD).</p> <p>Resident R158's current care plan, review completed on June 16, 2025, revealed a care plan for PTSD. Further review of the care plan did not address resident's actual diagnoses/condition of PTSD, identifying the resident's past experiences and possible triggers that may cause re-traumatization.</p> <p>Interview with the Social Service Director, Employee E10, on June 20, 2025, at 10:16 a.m. confirmed that Resident R130's care plan for PTSD did not include resident's actual diagnoses/condition of PTSD, identifying the resident's past experiences and possible triggers that may cause re-traumatization.</p> <p>28 Pa. Code 211.12(c)(d)(3)(5) Nursing services</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>Based on review of facility documentation, observations, and resident and staff interviews, it was determined that the facility failed to provide food and drink that was palatable and served at the proper temperature.</p> <p>Findings include:</p> <p>Interview with Resident R80 on June 16, 2025 at 11:23am revealed that food does not taste good.</p> <p>Interview with Resident R230 on June 16, 2025 at 1:07pm revealed that food does not taste good and is not cooked to right temperatures, tends to be overdone or underdone depending on the dish.</p> <p>Interview conducted with Resident R137, during dining on June 16, 2025, at 1:27 p.m. revealed that the food was cold.</p> <p>During a group interview on June 18, 2025, at 10:03 p.m. when food was brought up and all the residents agreed that there were problems with the food. Residents R33, R110, and R230, stated that last week, chicken was served partially raw with visible blood.</p> <p>Observations during a test tray conducted with the Dietitian, Employee E9, on June 18, 2025, at 1:01 p.m. revealed pasta registered at 107.6 degrees Fahrenheit (F); green beans registered at 102.5 degrees F; salmon at 109.5 degrees F; and orange juice at 52.5 degrees F.</p> <p>Follow-up interview with the Dietitian, at 1:20 a.m. confirmed that the tested food items were too cool to be palatable.</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code 201.18(b)(3) Management</p> <p>28 Pa. Code 201.14(a) Responsibility of licensee</p> <p>28 Pa. Code 201.18(b)(3) Management</p> <p>28 Pa. Code 211.6(f) Dietary services</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of facility policies, review of facility documentation, clinical record review and interviews with staff, it was determined that the facility failed to maintain an effective infection control program related with Enhanced Barrier Precautions for one of 14 residents reviewed (R142).</p> <p>Findings include:</p> <p>Review of literature revealed that Enhanced Barrier Precautions are infection control intervention designed to reduce the transmission of novel or Multi-Drug-Resistant Organisms. Enhanced Barrier Precautions require to employ the use of targeted Personal Protective Equipment (PPE) during high contact patient/resident activities.</p> <p>Review of Resident R142's clinical record revealed that the resident was admitted to the facility on [DATE] with the diagnoses of Dependence on Renal Dialysis, and Obstructive and Reflux Uropathy Obstructive Unspecified (Reflux Uropathy Obstructive Unspecified refers to a condition where there's a blockage in the urinary tract that prevents normal urine flow.</p> <p>Review of physician order dated June 2, 2025, for Resident R142, indicated an order stating, Enhanced Barrier Precautions Every Shift.</p> <p>On June 17, 2025, at 10:52 a.m., observed Ophthalmologist (eye doctor), E8, was providing Eye-Examination -Care to Resident R142, without wearing a protective gown as part of the PPE.</p> <p>At the time of the finding, the same was confirmed with Employee E8.</p> <p>28 Pa Code 201.14(a) Responsibility of licensee</p> <p>28 Pa Code 201.18(d) Management</p>		