STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396078	A. BLDG: __--_____ B. WING: _____	02/10/2025

NAME OF PROVIDER OR SUPPLIER:	STREET ADDRESS, CITY, STATE, ZIP CODE:
HORSHAM CENTER FOR JEWISH LIFE STATE LICENSE NUMBER: **09130200**	**1425 HORSHAM ROAD NORTH WALES, PA 19454**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE
E 0000	INITIAL COMMENT Based on an Emergency Preparedness Survey completed on February 10, 2025, at Horsham Center for Jewish Life, it was determined there were no deficiencies identified with the requirements of 42 CFR 483.73.	E 0000		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

Certified End Page

HORSHAM CENTER FOR JEWISH LIFE

STATE LICENSE NUMBER: 09130200

SURVEY EXIT DATE: 02/10/2025

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeanne Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen MD
Debra L. Bogen, MD, FAAP
Secretary of Health

Pennsylvania
Department of Health

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
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K 0000	INITIAL COMMENT Facility ID 09130200 Component 01 Main Building Based on a Medicare/Medicaid Recertification Survey completed on February 10, 2025, it was determined that Horsham Center for Jewish Life was not in compliance with the following requirements of the Life Safety Code for an existing Nursing health care occupancy. Compliance with the National Fire Protection Association's Life Safety Code is required by 42 CFR 483.90(a). This is a three-story, Type II (222), fire resistive construction, with a basement, which is fully sprinklered.	K 0000		

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

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K 0100 SS=E	NFPA 101 General Requirements - Other General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. This REQUIREMENT is not met as evidenced by:	K 0100	Preparation and/or execution of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State Law. The plan of correction represents the facility's credible allegation of compliance. Battery was changed on the carbon monoxide detector in basement laundry. All Carbon monoxide detectors were checked for batteries not exceeding annual requirements. Maintenance director will in-service maintenance staff on maintaining the required regulation set forth in PA Act 48 for carbon monoxide detectors Carbon monoxide detectors were added to the tasks in TELS to ensure batteries are changed timely. Any findings will be reported to QAPI committee.	Completion Date: **04/03/2025** Status: **APPROVED** Date: **03/05/2025**

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K 0100 SS=E	Continued from page 2 Based on observation and interview, the facility failed to maintain the required regulations set forth by Pennsylvania Act 48 for carbon monoxide detectors affecting one of four levels. Findings include: Observation on February 10, 2025, at 11:30 a.m., revealed the carbon monoxide detector in basement laundry indicated the battery was last changed June 8, 2023, exceeding the annual requirement. Exit interview with the Administrator and Maintenance Director on February 10, 2025, at 1:45 p.m., confirmed the battery deficiency.	K 0100		
K 0291 SS=C		K 0291		

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K 0291 SS=C	Continued from page 3 NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by:	K 0291	Emergency lighting fixture within the generator enclosure was repaired. All emergency lighting was checked to ensure working properly when tested. Maintenance director will in-service maintenance staff to maintain emergency lighting in operable condition. Random weekly audit to check emergency lighting is in operable condition for 3 weeks and report findings to QAPI.	Completion Date: **04/03/2025** Status: **APPROVED** Date: **03/05/2025**

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K 0291 SS=C	Continued from page 4 Based on observation and interview, it was determined the facility failed to maintain emergency lighting in operable condition, in one location within this facility. Findings include: Observation made on February 10, 2025, at 12:10 p.m., revealed, within the generator enclosure, the emergency back-up battery lighting fixture failed to illuminate when tested. Exit interview with the Administrator and Maintenance Director on February 10, 2025, at 1:45 p.m., confirmed the emergency back-up battery lighting fixture failed to work when tested.	K 0291		
K 0325 SS=E		K 0325		

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K 0325 SS=E	Continued from page 5 NFPA 101 Alcohol Based Hand Rub Dispenser (ABHR) Alcohol Based Hand Rub Dispenser (ABHR) ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met: * Corridor is at least 6 feet wide * Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols * Dispensers shall have a minimum of 4-foot horizontal spacing * Not more than an aggregate of 10 gallons of fluid or 135 ounces aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room * Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30 * Dispensers are not installed within 1 inch of an ignition source * Dispensers over carpeted floors are in sprinklered smoke compartments * ABHR does not exceed 95 percent alcohol * Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11) * ABHR is protected against inappropriate access 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485 This REQUIREMENT is not met as evidenced by:	K 0325	ABHR dispenser was removed from the basement kitchen above light switch and duplex electrical outlet. All ABHR dispensers were checked for appropriate placement in accordance with guidelines. Maintenance Director will in-service all maintenance staff on proper installation and placement of ABHR dispenser. Random weekly audit of ABHR dispensers for placement will be completed for 3 weeks and findings reported to QAPI.	Completion Date: **04/03/2025** Status: **APPROVED** Date: **03/05/2025**

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K 0325 SS=E	Continued from page 6 Based on observation and interview, it was determined the facility failed to protect Alcohol Based Hand Rub Dispenser (ABHR), affecting one of four levels. Findings include: Observation on February 10, 2025, at 10:40 a.m., revealed an ABHR was installed directly above a light switch and a duplex electrical outlet, basement kitchen. Exit interview with the Administrator and Maintenance Director on February 10, 2025, at 1:45 p.m., confirmed the ABHR location.	K 0325		
K 0351 SS=E		K 0351		

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K 0351 SS=E	Continued from page 7 NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by:	K 0351	A. Facility is submitting time limit waiver to obtain quotes for the portico sprinkler install or proof of sufficient fire safety rating B. The sprinkler pendant was removed, and proper upright sprinkler head was installed in the synagogue telephone room. Sprinkler heads/pendants will be checked for proper installation. Maintenance director will in-service maintenance staff on proper sprinkler system components/installation. Random weekly audit of sprinkler heads/pendants will be completed X 3 weeks and findings will be reported to QAPI.	Completion Date: **04/03/2025** Status: **APPROVED** Date: **03/06/2025**

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K 0351 SS=E	Continued from page 8 Based on observation and interview, it was determined the facility failed to properly install sprinkler system components, affecting one of four levels. Findings include: 1. Observation made on February 10, 2025, at 1:10 p.m., revealed missing sprinkler protection of what appeared to be a combustible material of the main entrance, exterior portico ceiling. Exit interview with the Administrator and Maintenance Director on February 10, 2025, at 1:45 p.m., confirmed the missing sprinkler protection. 2. Observation on February 10, 2025, at 1:15 p.m., revealed in the Synagogue telephone room, a pendant sprinkler was installed in an area lacking a ceiling assembly. Exit interview with the Administrator and	K 0351		

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K 0351 SS=E	Continued from page 9 Maintenance Director on February 10, 2025, at 1:45 p.m., confirmed incomplete sprinkler coverage.	K 0351		
K 0353 SS=E		K 0353		

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K 0353 SS=E	Continued from page 10 NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by:	K 0353	A. Stored boxes were removed from the second floor C storage room to ensure proper clearance of sprinkler heads and signage/tape installed. B. White cardboard was removed from the sprinkler head on first floor main lobby next to front desk and was fixed using 5/8 sheetrock. C. Annual inspection of the clean agent suppression system by basement IT will be completed by 4/3/2025. D. 3 butterfly valves will be reinspected, and retest will be completed by 4/3/2025. All storage areas are checked to ensure proper clearance of sprinkler heads and sprinkler heads will be checked for anything that could negatively impact operation. All inspections and documentation were completed to ensure sprinkler system is in accordance with NFPA 25 Maintenance director will in-service maintenance staff on maintaining automatic sprinkler system components in accordance with NFPA 25	Completion Date: **04/03/2025** Status: **APPROVED** Date: **03/06/2025**

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K 0353 SS=E	Continued from page 11	K 0353	Random weekly audits of sprinkler system components will be completed X 3 weeks and findings reported to QAPI.	

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K 0353 SS=E	Continued from page 12 Based on observation and interview, it was determined the facility failed to maintain automatic sprinkler system components, affecting two of four levels. Findings include: 1. Observation on February 10, 2025, at 11:50 a.m., revealed stored boxes within 18 inches of the sprinkler, on the second floor C Corridor Storage Room. Exit interview with the Administrator and Maintenance Director on February 10, 2025, at 1:45 p.m., confirmed the boxes stored near the sprinkler. 2. Observation on February 10, 2025, at 12:55 p.m., revealed a missing section of drywall ceiling, replaced with white cardboard, surrounding a sprinkler which could negatively affect sprinkler activation, on the first floor Main Lobby next to the front desk.	K 0353		

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K 0353 SS=E	Continued from page 13 Exit interview with the Administrator and Maintenance Director on February 10, 2025, at 1:45 p.m., confirmed the damaged ceiling surrounding a sprinkler head. 3. Document review on February 10, 2025, at 8:30 a.m., revealed the facility could not provide the annual inspection of the clean agent suppression system, Basement IT Room. Exit interview with the Administrator and Maintenance Director on February 10, 2025, at 1:45 p.m., confirmed the missing documentation. 4. Document review on February 10, 2025, at 8:30 a.m., revealed the October 19, 2022, 5 Year Internal Valve Inspection report listed that 3 butterfly valves needed to be replaced, evidence of corrective action and retest was not available at time of survey. Exit interview with the Administrator and	K 0353		

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K 0353 SS=E	Continued from page 14 Maintenance Director on February 10, 2025, at 1:45 p.m., confirmed the missing documentation.	K 0353		
K 0355 SS=D	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by:	K 0355	The broken fire extinguisher housing box by A201 was replaced. All fire extinguisher housing boxes were checked to ensure integrity. Maintenance director will in-service maintenance staff to ensure NFPA 101 Portable fire extinguishers. Random weekly audit of portable fire extinguishers and housing will be checked for integrity X3 weeks and findings will be reported to QAPI.	Completion Date: **04/03/2025** Status: **APPROVED** Date: **03/05/2025**

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K 0355 SS=D	Continued from page 15 Based on observation and interview, it was determined the facility failed to maintain fire extinguisher housing integrity, affecting one fire extinguisher. Findings include: Observation made on February 10, 2025, at 10:57 a.m., revealed on the second floor across from resident room A201, a broken fire extinguisher housing box. Exit interview with the Administrator and Maintenance Director on February 10, 2025, at 1:45 p.m., confirmed the broken fire extinguisher housing.	K 0355		
K 0372 SS=E		K 0372		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION:	(X3) DATE SURVEY COMPLETED:
	396078	A. BLDG: __01_____ B. WING: _____	02/10/2025

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HORSHAM CENTER FOR JEWISH LIFE STATE LICENSE NUMBER: **09130200**	**1425 HORSHAM ROAD NORTH WALES, PA 19454**

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K 0372 SS=E	Continued from page 16 NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by:	K 0372	The penetration around data wires above smoke doors on D1 was sealed using LC Endothermic Firestop Sealant. System number CAJ0047 with an F rating of 2 hours and a T rating of 2 hours. The maintenance team filled the void in accordance with manufactures specifications. Maintenance department will check behind work orders/vendors to ensure all penetrations are sealed properly. Maintenance director will in-service staff on maintaining smoke barrier walls free of unsealed penetrations. Random weekly audit of smoke barrier walls will be conducted X3 weeks and findings will be reported to QAPI.	Completion Date: **04/03/2025** Status: **APPROVED** Date: **03/12/2025**

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K 0372 SS=E	Continued from page 17 Based on observation and interview, it was determined the facility failed to maintain smoke barrier walls free of unsealed penetrations, affecting one of four levels. Findings include: Observation on February 10, 2025, at 12:20 p.m., revealed an unsealed penetration around data wires, above the smoke doors to first floor D-1. Exit interview with the Administrator and Maintenance Director on February 10, 2025, at 1:45 p.m., confirmed the penetration.	K 0372		
K 0911 SS=E		K 0911		

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K 0911 SS=E	Continued from page 18 NFPA 101 Electrical Systems - Other Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by:	K 0911	The junction box in the basement chiller room ceiling was repaired. The duplex receptacle on the third floor C/D kitchenette was replaced. All electrical panels and wiring will be inspected and repairs made as needed. Maintenance will be in-serviced on electrical requirements in accordance with NFPA 99 Random weekly audit of electrical panels and receptacles will be conducted X3 weeks and findings reported to QAPI.	Completion Date: **04/03/2025** Status: **APPROVED** Date: **03/05/2025**

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K 0911 SS=E	Continued from page 19 Based on observation and interview, it was determined facility failed to maintain protection of electrical wiring, affecting two of four levels. Findings include: 1. Observation on February 10, 2025, at 12:00 p.m., revealed a junction box was missing its protective cover, exposing the inner wiring, in the basement, chiller room ceiling. Exit interview with the Administrator and Maintenance Director on February 10, 2025, at 1:45 p.m., confirmed the exposed wiring. 2. Observation on February 10, 2025, at 12:05 p.m., revealed a damaged duplex receptacle, exposing the inner wiring, on the third floor, C/D Kitchenette. Exit interview with the Administrator and Maintenance Director on February 10, 2025, at 1:45 p.m., confirmed the exposed wiring.	K 0911		

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K 0911 SS=E	Continued from page 20	K 0911		
K 0918 SS=F	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new	K 0918	3 year, 4hour load test was completed on 2/26/25. All generator tests will be scheduled in TELS for timely completion. Maintenance staff will be in-serviced on timely completion of generator tests and documentation. The maintenance director/designee will do a random audit to ensure that generator tests and documentation are completed timely, findings reported to QAPI.	Completion Date: **04/03/2025** Status: **APPROVED** Date: **03/05/2025**

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K 0918 SS=F	Continued from page 21 installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on document review and interview, it was determined the facility failed to maintain and test the generator, affecting the entire facility. Findings include: Document review on February 10, 2025, at 8:30 a.m., revealed the facility could not produce documentation of 3-year, 4-hour load test. Exit interview with the Administrator and Maintenance Director on February 10, 2025, at 1:45 p.m., confirmed the missing documentation.	K 0918		
K 0920 SS=E		K 0920		

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K 0920 SS=E	Continued from page 22 NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by:	K 0920	Extension cord was removed from inside the electrical panel on the C/D corridor storage room. Facility will prohibit the improper use of electrical devices in the facility. Maintenance staff will be in-serviced on proper use of electrical devices. A random weekly audit X3 weeks to ensure no improper use of electrical devices, findings reported to QAPI .	Completion Date: **04/03/2025** Status: **APPROVED** Date: **03/05/2025**

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K 0920 SS=E	Continued from page 23 Based on observation and interview, it was determined the facility failed to prohibit the improper and unauthorized use of electrical devices on one of four levels. Findings include: Observation on February 10, 2025, at 11:45 a.m., revealed an orange extension cord plugged into a surge protector, inside electrical panel labeled PNL-MEC09, on the second floor, C/D Corridor Storage Room. Exit interview with the Administrator and Maintenance Director on February 10, 2025, at 1:45 p.m., confirmed the extension cord plugged into a surge protector.	K 0920		
K 0923 SS=E		K 0923		

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K 0923 SS=E	Continued from page 24 NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders	K 0923	Combustible boxes were removed from oxygen storage room next to cylinders located in the basement. Empty portable oxygen cylinders were separated from full cylinders in the basement storage room. All oxygen storage areas will be checked for proper storage of cylinders. Maintenance director will in-service Material management on proper oxygen storage requirements The maintenance director/designee will audit O2 storage areas for proper storage of cylinders weekly X3 and report findings to QAPI.	Completion Date: **04/03/2025** Status: **APPROVED** Date: **03/05/2025**

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K 0923 SS=E	Continued from page 25 are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by:	K 0923		

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K 0923 SS=E	Continued from page 26 Based on observation and interview, it was determined that the facility failed to maintain oxygen storage requirements, affecting one of four levels. Findings include: Observation on February 10, 2025, revealed the following oxygen storage deficiencies: a. 11:45 a.m., in the basement, oxygen storage room- combustible boxes stored directly next to oxygen cylinders. b. 11:46 a.m., in the basement, oxygen storage room - empty portable oxygen cylinders were not separated from full portable oxygen cylinders. Exit interview with the Administrator and Maintenance Director on February 10, 2025, at 1:45 p.m., confirmed the oxygen storage deficiencies.	K 0923		

Certified End Page

HORSHAM CENTER FOR JEWISH LIFE

STATE LICENSE NUMBER: 09130200

SURVEY EXIT DATE: 02/10/2025

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey

Jeanne Parisi
Deputy Secretary for Quality Assurance

Debra L. Bogen MD
Debra L. Bogen, MD, FAAP
Secretary of Health

Pennsylvania
Department of Health

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY