STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315280	A. BUILDING _____ B. WING _____	C 05/12/2022

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SILVER HEALTHCARE CENTER	1417 BRACE ROAD CHERRY HILL, NJ 08034

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F 000	INITIAL COMMENTS COMPLAINT: # NJ15116, #NJ153829, #NJ154125 CENSUS: 105 SAMPLE SIZE: 3 THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)	F 580		6/17/22

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 06/09/2022

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F 580	Continued From page 1 (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: C#: NJ151116 Based on interviews, medical record review, and review of other pertinent facility documents on 5/10/2022 and 5/12/2022, it was determined that the facility failed to notify the Resident's responsible party for a resident who had a change in condition; developed pressure wounds, and also failed to follow its policies titled, "Change	F 580	F580 1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice: Based on the record review and interviews and reviews of pertinent documents, the facility failed to notify the resident□s	

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F 580	Continued From page 2 in Condition Monitoring" and "Wound Care and Prevention" for 1 of 3 residents (Resident #2). This deficient practice was evidenced by the following: A review of Resident #2's Medical Record was as follows: According to the "Admission Record (AR)," Resident #2 was admitted to the facility on NJ Exec. Order 26 4.b.1 with diagnoses which included, NJ Exec. Order According to the Minimum Data Set (MDS), dated 7/7/2021, Resident #2 had NJ Exec. Order 26:4.b.1 . The MDS also showed Resident #2 needed NJ Exec. Order 26:4.b.1 . A review of "Admission/Re-admission Screener" for Resident #2 dated 07/01/2021, written by the Licensed Practical Nurse (LPN #1), indicated Under "Skin Integrity," 'NJ Exec. Order 26:4.b.1 Resident #2 was admitted with NJ Exec. Order 26:4.b.1 . A review of PNs dated 10/8/2021 at 10:13 p.m. written by LPN #2 revealed that the Aide reported NJ Exec. Order 26:4.b.1 Will have the wound team consulted for any recommendations.	F 580	responsible party for the patient who had a change of condition for one (Resident #2) of three residents reviewed for pressure ulcers. The resident is no longer at Silver Healthcare Center. An audit of all residents with pressure ulcers was conducted to identify any residents in need of change in condition notification. Family notification complete. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected by this deficient practice. 3. What measures will be put into place or systematic changes made to ensure that the deficient practice will not return: DON/designee will provide retraining to all nurses regarding family notification on change of condition. 4. How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not reoccur: DON/designee will conduct weekly audits of patient pressure ulcers to ensure family notification on change of condition was completed. This audit will continue for three (3)	

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F 580	Continued From page 3 A review of PNs dated 11/2/2021 at 9:21 p.m. written by LPN #1 revealed that Resident #2 was noted with NJ Exec. Order 26:4.b.1 Will follow up with MD (physician) and wound doctor. A review of the "Wound Report (WR)" for Resident #2 with an effective date of 11/2/2021 written by the Unit Manager/Licensed Practice Nurse (UM #1) with a signed date of 11/8/2021 revealed under "Wound 1" showed Resident #2 had NJ Exec. Order 26:4.b.1 A review of the WR for Resident #2 with an effective date of 11/2/2021 written by UM #1 and a signed date of 11/8/2021 revealed that Under "Wound 2" indicated Resident #2 had NJ Exec. Order 26:4.b on 11/2/2021. A review of the WR for Resident #2 with an effective date of 11/9/2021 written by UM #1 with a signed date of 11/12/2021 revealed under "Wound 4" indicated Resident #2 had NJ Exec. Order 26:4.b.1 on 11/8/2021 and Under "Wound 5" showed Resident #2 had NJ Exec. Order 26:4.b.1 with no documented date and treatment ordered. A review of the WR for Resident #2 with an effective date of 11/30/2021 written by UM #1 with a signed date of 11/30/2021 revealed Under "Wound 5," a facility acquired, NJ Exec. Order 26:4.b.1 on 11/8/2021. A review of the WR for Resident #2 with an	F 580	months or until compliance is achieved. Monthly report of this process will be provided to administration and a quarterly report will be reported to quality assurance performance improvement committee for one year.	

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F 580	Continued From page 4	F 580		

effective date of 12/14/2021 written by UM #1 with a signed date of 12/14/2021 did not reveal any NJ Exec. Order 26:4.b.1 for Resident #2.

A review of a Wound Care Visit Report for Resident #2 dated 12/13/2021 revealed NJ Exec. Order 2 noted by the Wound Consultant, Advanced Practice Nurse (APN).

A further review of the PNs showed no documented evidence that the facility staff notified Resident 2's responsible party of the changes in the Resident's skin condition or wounds from 10/8/2021 until discharge.

During an interview on 5/10/2022 at 10:25 a.m., UM #1 stated the nurse should notify the family on the day of discovering the wound, and the notification would be documented in the Nurse's (Progress) Notes (NN). UM, #1 could not recall if he notified the family member of the new wounds.

During an interview on 5/10/2022 at 12:36 p.m., the surveyor asked the Director of Nursing (DON) what the protocol was when a new wound was found. The DON stated the nurse would call the family and document what was found in the NN.

During an interview on 5/10/2022 at 3:28 p.m., the DON stated the nurses should have documented the wounds in the NN and that the family was notified.

During an interview on 5/12/022 at 11:00 a.m., the DON stated a change in condition includes redness to the sacrum and when there is a change in the stage of a wound. The documentation would be in a NN.

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During a post-survey telephone interview on 5/16/2022, LPN #1 stated when a new wound was found, "I would report it to the UM, and he would follow-up with the doctor (Physician) and family.

During a post-survey telephone interview on 5/17/2022 at 2:39 p.m., the Wound Consultants, APN, stated for Resident #2's wound consultations, the UM #1 was the point of contact for her and the family. She said her initial consultation with Resident #2 was on 11/5/2021, and her last was on 12/13/2021.

A review of the policy titled, "Change in Condition Monitoring" with a revision date of 6/29/2019 revealed Under "Policy" included: "Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care ...etc.)." Under "Policy Interpretation and Implementation" included: " ...2. A "significant change" of condition is a major decline or improvement in the resident's status that: ...b. Impacts more than one area of the resident's health status; ...4. Unless otherwise instructed by the resident, the Nurse Supervisor/Charge Nurse will notify the resident's family or representative (sponsor) when: ... b. There is a significant change in the resident's physical, mental, or psychosocial status ..."

A review of the facility policy with a revised date of January 2020, titled" Wound Care and Prevention," revealed the following: Under "Policy," included: "It is the policy of the facility to assess for the risk of and the presence of pressure ulcers or other skin alterations.

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F 580	Continued From page 6 Interventions to eliminate or minimize risk factors will be introduced at the earliest possible time ...Interventions for promotion of healing and prevention of infection to the extent possible will be initiated. Education will be provided to include staging, assessment of wound bed, infection, pain management and prevention, and treatment modalities. The wound protocols included in this policy will be followed unless another treatment regimen is ordered by the physician. In cases where there has been a lack of improvement of decline in a wound, a reassessment of the treatment will be conducted." Under "Procedure," included: "...12. The physician and the family/significant other will be notified when a wound is discovered or if a would worsens ..." Under "Wound Care Protocol" included: "General Protocols" "Notify....Family..."	F 580		
F 657 SS=D	N.J.A.C.: 8:39-13.1(c) Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of	F 657		6/17/22

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F 657	Continued From page 7 the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: C#: NJ151116 Based on interviews, medical record review, and review of other pertinent facility documents on 5/10/2022 and 5/12/2022, it was determined that the facility failed to update a Resident's Care Plan (CP) for new wounds as well as failed to follow its facility policies titled, "Policy: Care Plans-Comprehensive" and "Wound Care and Prevention" for 1 of 3 residents (Resident #2). This deficient practice was evidenced by the following: A review of Resident #2's Medical Record was as follows: According to the "Admission Record (AR)," Resident #2 was admitted to the facility on NJ Exec. Order 26 4.b.1 with diagnoses which included, NJ Exec. Order	F 657	F 657 1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice: Based on interviews, medical records review and review of other pertinent facility documents, it was determined that this facility failed to update the Resident□s Care Plan (CP) for new wounds for one (1) of three (3) residents (Resident # 2). The resident is no longer at Silver Healthcare Center. An audit of all residents with pressure ulcers was conducted to identify any resident□s records needing a care plan update for pressure ulcers. 2. How the facility will identify other residents having the potential to be affected by the	

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F 657	Continued From page 8 According to the Minimum Data Set (MDS), dated 7/7/2021, Resident #2 had NJ Exec. Order 26:4.b.1 [redacted]. The MDS also showed Resident #2 needed NJ Exec. Order 26:4.b.1 [redacted] A review of "Admission/Re-admission Screener" for Resident #2 dated 07/01/2021, written by the Licensed Practical Nurse (LPN #1), indicated Under "Skin Integrity," 'NJ Exec. Order 26:4.b.1 [redacted]. A review of PNs dated 10/8/2021 at 10:13 p.m. written by LPN #2 revealed that the Aide reported NJ Exec. Order 26:4.b.1 [redacted] ...Will have the wound team consulted for any recommendations. A review of Resident #2's "Wound Report (WR)" written by the UM/LPN #1 revealed the resident had the following facility acquired wounds: On 11/2/2021, Under "Wound 1" indicated Resident #2 had NJ Exec. Order 26:4.b.1. Under "Wound 2," indicated Resident #2 had NJ Exec. Order 26:4.b [redacted] On 11/9/2021, Under "Wound 4" indicated Resident #2 had NJ Exec. Order 26:4.b.1 [redacted] n 11/8/2021, and Under "Wound 5" showed a NJ Exec. Order 26:4.b.1 [redacted] with no documented date.	F 657	same deficient practice: All residents have the potential of being affected by this practice. 3. What measures will be put into place or systematic changes made to ensure that the deficient practice will not return: DON/designee will provide retraining to all Nurses regarding updating of the care plan for any change in skin integrity. 4. How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not reoccur: DON/designee will conduct weekly audits of patient pressure ulcers to ensure the care plan is updated with each change in skin integrity. This audit will continue for three (3) months or until compliance is achieved. Monthly report of this process will be provided to administration and a quarterly report will be reported to quality assurance performance improvement committee for one year.	

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F 657	Continued From page 9 On 11/30/2021, Under "Wound 5," revealed NJ Exec. Order 26:4.b.1 on 11/8/2021. A review of WR for Resident #2 with an effective date of 12/14/2021 written by UM/LPN #1 with a signed date of 12/14/2021 did not reveal any additional wounds for Resident #2. A review of a Wound Care Visit Report for Resident #2 dated 12/13/2021 NJ Exec. Order 26:4.b.1 noted by the Wound Consultant, Advanced Practice Nurse (APN). A review of Resident #2's Care Plan revealed Under Focus: "(Resident #2) dated 11/22/2021 revision on 09/26/2021 revealed Under Focus: "(Resident #2) has the potential for skin alteration: (Resident #2) has NJ Exec. Order 26:4.b.1 Under Goal: "(Resident #2) will continue to have skin intact through the next review date", date initiated 10/8/2021. Under Interventions: "NJ Exec. Order 26:4.b.1 initiated 08/22/2021, "Assess skin for changes in condition and report any changed to the doctor" date initiated 07/01/2021, NJ Exec. Orde date initiated 09/26/2021, NJ Exec. Order 26:4.b date initiated 08/22/021, NJ Exec. Order 26:4.b.1" date initiated 8/22/2021, NJ Exec. Order 26:4.b.1 date initiated 08/22/2021. Further review of the Resident #2's CP showed no documentation that the CP was updated with interventions for the aforementioned wounds. During an interview on 5/10/2022 at 10:25 a.m.,	F 657		

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the UM stated once we identify a pressure ulcer, we do an incident report, notify the family and the doctor (physician), and meet as the IDT (Interdisciplinary) team, gather information, discuss it, and put interventions in place. He continued to say the CP would be updated by myself or the Director of Nursing (DON), not the floor nurse.

During an interview on 5/12/2022 at 11:00 a.m., the DON stated the CP should be updated every time there is a change, and the CP is done by the nurse who noticed the change that day when he/she writes the (nurse) note. She continued to say there should be incident reports for each time a wound is found. The Wound report is not the incident report.

During a post-survey telephone interview on 5/12/2022 at 1:53 p.m., LPN#1 stated if there was a new wound, the nurse could update the CP, and the Unit Manager would make sure the CP was updated.

A review of the policy titled "Care Plans-Comprehensive" with a date of 01/05 revealed Under "Policy" included: "It is the policy of this facility to develop an individual and comprehensive care plan for each resident which includes measurable objectives and timetables to meet the resident's medical, nursing and psychological needs." Under "Procedure" included " ...3. The comprehensive care plan has been designed to: ...d. Reflect treatment goals and objectives in measurable outcomes; ... Prevent decline in the resident's functional status and/or functional levels; ...6 .... In the Pavilion (behavior management-dementia): The team will meet weekly and review the resident's plan of

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F 657	Continued From page 11 care monthly for the first quarter, and quarterly thereafter. Care plans are reviewed and updated as changes in the resident's condition dictates ...8 ....Any changes in the plan are communicated to the staff and any outside sources when appropriate ..." A review of the facility policy with a revised date of January 2020, titled" Wound Care and Prevention," revealed the following: Under "Policy," included: "It is the policy of the facility to assess for the risk of and the presence of pressure ulcers or other skin alterations. Interventions to eliminate or minimize risk factors will be introduced at the earliest possible time ...Interventions for promotion of healing and prevention of infection to the extent possible will be initiated. Education will be provided to include staging, assessment of wound bed, infection, pain management and prevention, and treatment modalities. The wound protocols included in this policy will be followed unless another treatment regimen is ordered by the physician. In cases where there has been a lack of improvement of decline in a wound, a reassessment of the treatment will be conducted." Under "Wound Care Protocol" included: "General Protocols" revealed: "...Update care plan..."	F 657		
F 686 SS=D	N.J.A.C. 8:39-27.1 (a) Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a	F 686		6/17/22

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F 686	Continued From page 12 resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: C#: NJ151116 Based on interviews and review of the medical record and other pertinent facility documents on 5/10/2022 and 5/12/2022, it was determined that the facility failed to provide evidence that a resident was consistently turned and repositioned and provided bowel and bladder incontinence care as well as failed to follow its policies titled "Policy: Charting and Documentation" and "Wound Care and Prevention" for 1 of 3 sampled residents (Resident #2). This deficient practice was evidenced by the following: A review of Resident #2's Medical Record was as follows: According to the "Admission Record (AR)," Resident #2 was admitted to the facility on [redacted] with diagnoses which included, [redacted] plications, and Unspecified Anxiety Disorder. According to the Minimum Data Set (MDS), dated	F 686	F 686 1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice: Based on the record review and interviews and reviews of pertinent documents, the facility failed to provide evidence that the resident was consistently turned and repositioned and provided bowel and bladder incontinence care as well as documenting and charting and wound care prevention for one (1) of three (3) sampled residents (Resident #2). The resident is no longer at Silver Healthcare Center. An audit of all residents with pressure ulcers or its potential (BRADEN scale) was conducted to identify any residents in need of turning and repositing, bowel and bladder incontinence care.	

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	315280	A. BUILDING _____ B. WING _____	C 05/12/2022

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F 686	Continued From page 13 7/7/2021, Resident #2 had NJ Exec. Order 26:4.b.1 . The MDS also showed Resident #2 NJ Exec. Order 26:4.b.1 and was admitted without wounds. A review of "Admission/Re-admission Screener" for Resident #2 dated 7/01/2021, written by the Licensed Practical Nurse (LPN #1), indicated Under "Skin Integrity," NJ Exec. Order 26:4.b.1 Resident #2 was admitted with no pressure wounds. A review of the "Braden Scale for Predicting Pressure Sore Risk Original" form for Resident #2 indicated Braden Scales done on admission on 7/1/2021 with a score of "NJ Exe" and on 7/13/2021 with a score of "NJ Exec"; both scores revealed Resident #2 was NJ Exec. Order 26:4.b.1 . A review of Progress Notes (PNs) dated 10/8/2021 at 10:13 p.m. written by LPN #2 revealed that the Aide reported NJ Exec. Order 26:4.b.1 Will have the wound team consulted for any recommendations. A review of PNs dated 11/2/2021 at 9:21 p.m. written by LPN #1 revealed that Resident #2 was noted with NJ Exec. Order 26:4.b.1 . Will follow up with MD (physician) and wound doctor.	F 686	2. How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected by this deficient practice. 3. What measures will be put into place or systematic changes made to ensure that the deficient practice will not return: DON/designee will provide retraining too all nurses and CNAs regarding turning and reposition, as well as provision of bowel and bladder incontinence care. 4. How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not reoccur: DON/designee will conduct weekly audits of patient pressure ulcers or its potential (BRADEN score) to assure that the residents are being appropriately turned and repositioned as well bowel and bladder incontinence care and its documentation of the procedures in the resident□s record. This audit will continue for three (3) months or until compliance is achieved. Monthly report of this process will be provided to administration and a quarterly report will be reported to quality assurance performance improvement committee for	

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F 686	Continued From page 14 A review of the "Wound Report (WR)" for Resident #2 with an effective date of 11/2/2021 written by the Unit Manager/Licensed Practice Nurse (UM #1) with a signed date of 11/8/2021 revealed under "Wound 1" showed Resident #2 had NJ Exec. Order 26:4.b.1 management. A review of WR for Resident #2 with an effective date of 11/2/2021 written by UM #1 with a signed date of 11/8/2021 revealed Under "Wound 2" indicated Resident #2 had a NJ Exec. Order 26:4.b.1 management. A review of WR for Resident #2 with an effective date of 11/9/2021 written by UM #1 with a signed date of 11/12/2021 revealed under "Wound 4" indicated Resident #2 had NJ Exec. Order 26:4.b.1 on 11/8/2021 with the following interventions: NJ Exec. Order 26:4.b.1 management and Under "Wound 5" showed Resident #2 had NJ Exec. Order 26:4.b.1 with no documented date and treatment ordered with the following interventions: NJ Exec. Order 26:4.b.1 management. A review of WR for Resident #2 with an effective date of 11/30/2021 written by UM #1 with a signed	F 686	one year.	

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date of 11/30/2021 revealed Under "Wound 5," a NJ Exec. Order 26:4.b.1 n 11/8/2021 with the following interventions: NJ Exec. Order 26:4.b.1 anagement.

At the time of the survey, Wound Consultant Visit Reports before November 2021 were not provided.

A review of a "Documentation Survey Report (DSR)" form used for ADL documentation of tasks for Resident #2 to be Turned and Reposition every 2 hours dated 7/1/2021 through 7/31/2021 revealed blank spaces which indicated the task was not documented as follows: on 7/2/2021, 7/15/2021, 7/22/2021, 7/25/2021, 7/29/2021 and 7/30/2021 on the 3:00 p.m.-11:00 p.m. shift; on 7/4/2021, 7/6/2021, 7/10/2021, 7/11/2021, 7/16/2021, 7/20/2021, 7/21/2021, 7/23/2021, 7/25/2021 and 7/29/2021 on the 7:00 a.m.-3:00 p.m. shift.

A review of the DSR form used for ADL documentation of tasks, Bladder Continence dated 7/1/2021 through 7/31/2021 revealed blank spaces which indicated the task was not documented as follows: on 7/1/2021, 7/9/2021, and 7/13/202 on the 11:00 p.m.-7:00 a.m. shift; on 7/2/2021, 7/15/2021, 7/22/2021 and 7/25/2021 on the 3:00 p.m.-11:00 p.m. shift; on 7/4/2021, 7/6/2021, 7/10/2021, 7/11/2021, 7/16/2021, 7/20/2021, 7/21/2021, 7/25/2021 and 7/29/2021 on the 7:00 a.m.-3:00 p.m. shift.

A review of the DSR form used for ADL documentation of tasks, Bowel Continence, and Movements dated 7/1/2021 through 7/31/2021

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revealed blank spaces which indicated the task was not documented as follows on: 7/1/2021, 7/9/2021, 7/13/2021 on the 11:00 p.m. -7:00 a.m. shift; on 7/2/2021, 7/15/2021, 7/22/2021 and 7/25/2021 on the 3:00 p.m.-11:00 p.m. shift; on 7/4/2021, 7/6/2021, 7/10/2021, 7/11/2021, 7/16/2021, 7/20/2021, 7/21/2021, 7/25/2021 and 7/29/2021 on the 7:00 a.m.-3:00 p.m. shift.

A review of a DSR form used for ADL documentation of tasks to Turn and Reposition every 2 hours dated 8/1/2021 through 8/31/2021 revealed blank spaces which indicated the task was not documented as follows: on 8/7/2021, 8/12/2021, 8/13/2021, 8/14/2021 and 8/29/2021 on the 7:00 a.m.-3:00 p.m. shift; on 8/7/2021, 8/8/2021, 8/21/2021, 8/23/2021, 8/27/2021, 8/29/2021 and 8/31/2021 on the 3:00 p.m. -11:00 p.m. shift.

A review of the DSR form used for ADL documentation of tasks, Bladder Continence dated 8/1/2021 through 8/31/2021 revealed blank spaces which indicated the task was not documented as follows: on 8/26/2021 on the 11:00 p.m. - 7:00 a.m.; on 8/7/2021, 8/8/2021, 8/21/2021, 8/23/2021, 8/27/2021, 8/29/2021 on the 3:00 p.m.-11:00 p.m. shift; on 8/7/2021, 8/8/2021, 8/12/2021, 8/13/2021, 8/14/2021, 8/24/2021 and 8/29/2021 on the 7:00 a.m.-3:00 p.m. shift.

A review of the DSR form used for ADL documentation of tasks, Bowel Continence, and Movements, dated 8/1/2021 through 8/31/2021 revealed blank spaces which indicated the task was not documented as follows on 8/26/2021 on the 11:00 p.m.-7:00 a.m. shift; on 8/7/2021, 8/8/2021, 8/21/2021, 8/23/2021, 8/27/2021,

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8/29/2021 and 8/31/2021 on 3:00 p.m.-11:00 p.m. shift; on 8/7/2021, 8/8/2021, 8/12/2021, 8/13/2021, 8/14/2021, 8/24/2021 and 8/29/2021 on 7:00 a.m.-3:00 p.m.shift.

A review of a DSR form used for ADL documentation of tasks to Turn and Reposition every 2 hours dated 9/1/2021 through 9/30/2021 revealed blank spaces which indicated the task was not documented as follows on 9/21/2021 and 9/28/2021 on the 11:00 p.m.-7:00 a.m. shift; on 9/4/2021, 9/9/2021, 9/10/2021, 9/11/2021, 9/17/2021, 9/19/2021, 9/21/2021, 9/23/2021, 9/24/2021, 9/25/2021 and 9/29/2021 on the 3:00 p.m.-11:00 p.m. shift.; on 9/9/2021, 9/11/2021, 9/12/2021, 9/13/2021, 9/16/2021, 9/18/2021, 9/19/2021, 9/20/2021 and 9/28/2021 on the 7:00 a.m.-3:00 p.m. shift.

A review of DSR form used for ADL documentation of tasks, Bladder Continence dated 9/1/2021 through 9/30/2021 revealed blank spaces which indicated the task was not documented as follows on 9/4/2021, 9/21/2021, 9/23/2021 and 9/28/2021 on the 11:00 p.m.-7:00 a.m. ; at 3:00 p.m.-11:00 p.m. on 9/4/2021, 9/9/2021, 9/10/2021, 9/11/2021, 9/17/2021, 9/19/2021, 9/21/2021, 9/23/2021, 9/24/2021, 9/25/2021 and 9/29/2021; at 7:00 a.m.-3:00 p.m. on 9/9/2021, 9/11/2021, 9/12/2021, 9/13/2021, 9/16/2021, 9/18/2021, 9/19/2021, 9/20/2021 and 9/28/2021.

A review of the DSR form used for ADL documentation of tasks, Bowel Continence, and Movements dated 9/1/2021 through 9/30/2021 revealed blank spaces which indicated the task was not documented as follows on 9/4/2021, 9/21/2021, 9/23/2021 and 9/28/2021 on the

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11:00-7:00 a.m. shift; on 9/4/2021, 9/9/2021, 9/10/2021, 9/11/2021, 9/17/2021, 9/19/2021, 9/21/2021, 9/23/2021, 9/24/2021, 9/25/2021 and 9/29/2021 on the 3:00 p.m.-11:00 p.m. shift and 9/9/2021, 9/11/2021, 9/12/2021, 9/13/2021, 9/16/2021, 9/18/2021, 9/19/2021, 9/20/2021 and 9/28/2021 on the 7:00 a.m.-3:00 p.m. shift.

A review of a DSR form used for ADL documentation of tasks to Turn and Reposition every 2 hours dated 10/1/2021 through 10/31/2021 revealed blank spaces which indicated the task was not documented as follows on 10/3/2021 on the 11:00 p.m.-7:00 a.m. shift; on 10/2/2021, 10/3/2021, 10/4/2021, 10/7/2021, 10/8/2021, 10/9/2021, 10/16/2021, 10/17/2021, 10/22/2021, 10/28/2021, 10/29/2021 on the 3:00 p.m. -11:00 p.m. shift; on 10/3/2021, 10/8/2021, 10/12/2021, 10/14/2021, 10/15/2021, 10/16/2021, 10/17/2021, 10/20/2021, 10/22/2021, 10/26/2021, 10/29/2021, 10/30/2021 and 10/31/2021 on the 7:00 a.m.-3:00 p.m. shift.

A review of the DSR form used for ADL documentation of tasks, Bladder Continence dated 10/1/2021 through 10/31/2021 revealed blank spaces which indicated the task was not documented as follows on 10/3/2021, 10/27/2021 on the 11:00 p.m. -7:00 a.m. shift; on 10/2/2021, 10/3/2021, 10/4/2021, 10/7/2021, 10/8/2021, 10/9/2021, 10/16/2021, 10/17/2021, 10/22/2021, 10/28/2021 and 10/29/2021 on the 3:00 p.m. -11:00 p.m. shift; on 10/3/2021, 10/8/2021, 10/12/2021, 10/14/2021, 10/15/2021, 10/16/2021, 10/17/2021, 10/20/2021, 10/22/2021, 10/26/2021, 10/29/2021, 10/30/2021 and 10/31/2021 on the 7:00 a.m.-3:00 p.m. shift.

A review of the DSR form used for ADL

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documentation of tasks, Bowel Continence, and Movements dated 10/1/2021 through 10/31/2021 revealed blank spaces which indicated the task was not documented as follows: on 10/3/2021 and 10/27/2021 on the 11:00 p.m. -7:00 a.m. shift; on 10/2/2021, 10/3/2021, 10/4/2021, 10/7/2021, 10/8/2021, 10/9/2021, 10/16/2021, 10/17/2021,10/22/2021, 10/28/2021 and 10/29/2021 on the 3:00 p.m. - 11:00 p.m. shift; on 10/3/2021, 10/8/2021, 10/12/2021, 10/14/2021, 10/15/2021, 10/16/2021, 10/17/2021, 10/20/2021, 10/22/2021, 10/26/2021, 10/29/2021, 10/30/2021 and 10/31/2021 on the 7:00 a.m.-3:00 p.m. shift.

A review of a DSR form used for ADL documentation of tasks to Turn and Reposition every 2 hours dated 11/1/2021 through 11/30/2021 revealed blank spaces which indicated the task was not documented as follows: on 11/1/2021, 11/2/2021, 11/5/2021, 11/10/2021, 11/13/2021, 11/14/2021, 11/15/2021 and 11/19/2021 on the 3:00 p.m.-11:00 p.m. shift; on 11/1/2021, 11/3/2021, 11/5/2021, 11/9/2021, 11/14/2021, 11/16/2021, 11/18/2021 11/23/2021 and 11/27/2021 on the 7:00 a.m.-3:00 p.m. shift.

A review of the DSR form used for ADL documentation of tasks, Bladder Continence dated 11/1/2021 through 11/30/2021 revealed blank spaces which indicated the task was not documented as follows: on 11/29/20211 on the 11:00 p.m.-7:00 a.m. shift; on 11/1/2021, 11/2/2021, 11/5/2021, 11/10/2021, 11/13/2021, 11/14/2021, 11/15/2021 and 11/19/2021 on the 3:00 p.m.-11:00 p.m. shift; on 11/1/2021, 11/3/2021, 11/5/2021, 11/9/2021, 11/14/2021, 11/18/2021, 11/23/2021 and 11/27/2021 on the 7:00 a.m.-3:00 p.m. shift.

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A review of the DSR form used for ADL documentation of tasks, Bowel Continence, and Movements dated 11/1/2021 through 11/30/2021 revealed blank spaces which indicated the task was not documented as follows: on 11/1/2021, 11/2/2021, 11/5/2021, 11/10/2021, 11/13/2021, 11/14/2021, 11/15/2021 and 11/19/2021 on the 3:00 p.m.-11:00 p.m. shift; on 11/1/2021, 11/3/2021, 11/5/2021, 11/9/2021, 11/14/2021, 11/18/2021, 11/23/2021 and 11/27/2021 on the 7:00 a.m.-3:00 p.m. shift.

A review of a DSR form used for ADL documentation of tasks to Turn and Reposition every 2 hours dated 12/1/2021 through 12/31/2021 revealed blank spaces, which indicated the task was not documented as follows: on 12/4/2021 and 12/12/2021 on the 3:00 p.m.-11:00 p.m. shift; on 12/3/2021, 12/7/2021, 12/10/2021 and 12/12/2021 on the 7:00 a.m.-3:00 p.m. shift.

A review of the DSR form used for ADL documentation of tasks, Bladder Continence dated 12/1/2021 through 12/31/2021 revealed blank spaces which indicated the task was not documented as follows: on 12/2/2021, 12/7/2021, and 12/13/2021 on the 11:00 p.m.-7:00 a.m. shift; on 12/4/2021 and 12/12/2021 on the 3:00 p.m.-11:00 p.m. shift; on 12/3/2021, 12/7/2021 and 12/12/2021 on the 7:00 a.m.-3:00 p.m. shift.

A review of the DSR form used for ADL documentation of tasks, Bowel Continence, and Movements dated 12/1/2021 through 12/31/2021 revealed blank spaces, which indicated the task was not documented as follows: on 12/4/2021 and 12/12/2021 on the 3:00 p.m.- 11:00 p.m. shift; on 12/3/2021, 12/7/2021 and 12/12/2021 on

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the 7:00 a.m.-3:00 p.m. shift.

There was no other documentation provided for the aforementioned dates to Turn and Reposition every 2 hours, Bladder Continence and Bowel Continence, and Movements for Resident #2 at the time of the survey.

Further review of Resident #2's MR showed no other Braden scale evaluations after the Resident developed the aforementioned wounds.

During an interview on 5/12/2022 at 9:53 a.m., the Certified Nursing Assistant (CNA) stated that she remembered Resident #2, and she, the Aide, turns and repositions, moves the Resident every 2 hours. The CNA continued to say it (the task) was documented in the kiosk plan of care. When the surveyor showed her the blank spaces on the DSR form, the CNA continued to say, "I don't know what the blank spaces mean; I never saw the paper before today."

During an interview on 5/12/2022 at 11:00 a.m., the Director of Nursing (DON) stated that Resident #2 would get out of bed. There is no order for turning and repositioning. The CNAs would do the turning and repositioning care and document on the kiosk. The DON further stated she didn't know what the blank spaces meant on the ADL sheet; she would clarify with the Unit Manager/Licensed Practice Nurse (UM/LPN).

During an interview on 5/12/2022 at 11:25 a.m., in the presence of the DON, when the surveyor showed the UM/LPN the DSR forms blank spaces for Resident #2, the UM/LPN stated the blanks (spaces) mean it (task) was not documented that day. When the surveyor asked if

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315280	A. BUILDING _____ B. WING _____	C 05/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER HEALTHCARE CENTER	1417 BRACE ROAD CHERRY HILL, NJ 08034

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 22	F 686		

it wasn't documented, does it mean it wasn't done? The UM/LPN further stated, "I agree if it is not documented, it is not done."

During the same interview on 5/12/2022 at 11:25 a.m., when the surveyor asked about the CNA documentation on the DSR forms, the DON stated the CNAs do ADLs, and the nurse does focus charting. She continued to say there is no ADL charting policy; the only Policy is the "Charting and Documentation" based on focus charting for nurses. The DON further stated we had a change in wound care (consultants). She explained in July that there was one wound care consultant, and at the end of October, there was a lapse in wound care consultants, then the current wound care consultants came in November. She continued to say she gave me all of the Wound Consultant Visit Reports she had for Resident #2.

During an interview on 5/12/2022 at 12:33 p.m., when the surveyor asked the DON about the Braden Scale Assessment Tool for Resident #2, she stated that Resident #2 should have a Braden Score/Scale done for every skin change.

During an interview on 5/12/2022 at 1:00 p.m., the UM stated no other Braden Scale forms were in the MR for Resident #2.

During a post-survey telephone interview on 5/13/2022 at 9:44 a.m., the Vascular Physician's Nurse Practitioner (NP) stated poor circulation causes ulceration and no pressure issues. On 12/14/2021, the wound care team at the hospital said Resident #2's NJ Exec. Order 26:4.b.1

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F 686	Continued From page 23 During a post-survey telephone interview on 5/17/2022 at 2:39 p.m., the Advanced Practice Nurse (APN) from the Wound Consultants stated for Resident #2's NJ Exec. Order 26:4.b.1 [redacted] caused Resident #2's NJ Exec. Order 26:4 to progress significantly. A review of 01/05 facility policy titled "Charting and Documentation" revealed the following: Under "Policy" included "It is the policy of this facility that each resident will have a clinical record which is a concise account of treatment, care, response to care, signs, symptoms and progress of the resident's condition. Data needed for identification and communication with family and friends will be included. It will also include a complete history of the resident as required under current law and regulations at the time of resident's admission." A review of the facility Policy with a revised date of January 2020, titled" Wound Care and Prevention," revealed the following: Under "Policy," included: "It is the policy of the facility to assess for the risk of and the presence of pressure ulcers or other skin alterations. Interventions to eliminate or minimize risk factors will be introduced at the earliest possible time ...Interventions for promotion of healing and prevention of infection to the extent possible will be initiated. Education will be provided to include staging, assessment of wound bed, infection, pain management and prevention, and treatment modalities. The wound protocols included in this	F 686		

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315280	A. BUILDING _____ B. WING _____	C 05/12/2022

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F 686	Continued From page 24 policy will be followed unless another treatment regimen is ordered by the physician. In cases where there has been a lack of improvement of decline in a wound, a reassessment of the treatment will be conducted." Under "Procedure," included: "1. The Braden scale will be the standard research-based screening/assessment tool. The Braden scale will be completed on admission, re-admission, quarterly, and when a significant change in status occurs ....5. The resident will be repositioned or reminded and/or educated as needed to reposition or shift their weight at a minimum of every 2 hours or as individually assessed ...7. Incontinent care and/or toileting programs will be implemented as individually assessed ...13. An incident report and investigation will be completed on all in-house acquired wounds. 14. All wounds will be submitted to the nursing office on the weekly tracking tool for tracking and trending and facility quality assurance review ..." N.J.A.C. 8:39-27.1 (e)	F 686		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315280	A. Building B. Wing	6/23/2022

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER HEALTHCARE CENTER	1417 BRACE ROAD CHERRY HILL, NJ 08034

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0580 Reg. # 483.10(g)(14)(i)-(iv)(15) LSC	Correction Completed 06/23/2022	ID Prefix F0657 Reg. # 483.21(b)(2)(i)-(iii) LSC	Correction Completed 06/23/2022	ID Prefix F0686 Reg. # 483.25(b)(1)(i)(ii) LSC	Correction Completed 06/23/2022
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
5/12/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO