STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315280	A. BUILDING _____ B. WING _____	C 06/05/2024

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 DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
F 000	INITIAL COMMENTS Complaint #: NJ 169959, 172797, 172731, 172664, 173098, 173137, 173170, 173420, 173499, 173568, 173837, 173857, 174044 Survey Date: 06/05/2024 Census: 115 Sample: 35+3 closed records A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey. The facility is in compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities based on this complaint survey.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and review of	F 558	1. The bathroom in room NJ Exec was	7/15/24

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

Electronically Signed | 06/21/2024

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F 558	Continued From page 1 pertinent facility documents, it was determined that the facility failed to promote resident NJ Exec Order and ensure a safe, clean, comfortable, homelike, environment when a resident was transferred into a private room without a functional bathroom or accessible handwashing sink. This deficient practice was identified on 1 of 4 Units (NJ Exec Order 26.4 and for 1 of 1 resident (Resident #37) observed for accommodation of needs. This deficient practice was evidenced by the following: On 05/29/2024 at 10:07 AM, the surveyor entered Resident #37's room and noted that the room smelled of dampness and the resident's bathroom had a sign posted on the door that depicted a toilet and the door was bolted shut from the outside. The resident was not in the room at the time of the observation. The surveyor observed US FOIA (b)(6) outside of the room in the hallway. When interviewed, US FOIA (b)(6) stated that the resident's bathroom was closed off after the sheet rock buckled due to water damage both on the inside and outside of the bathroom wall which rendered the bathroom unsafe for resident use so he locked it shut. US FOIA (b)(6) was unable to state when the door was locked shut. US FOIA (b)(6) stated that sheet rock was ordered last week and he had not yet received the materials to begin the repairs. A review of Resident #37's Admission Record revealed that the resident was admitted to the facility NJ ex order 26.4b1 [redacted]	F 558	inaccessible due to damage that requires remediation. Resident #37 NJ ex order 26.4b1 [redacted] Staff were educated to ensure that residents are provided reasonable accommodations. 2. All residents have the potential to be affected by this deficient practice when required repairs are needed and affect reasonable accommodations. An audit was completed to ensure all residents have reasonable accommodation. 3. On 6/5/2024 An in-service was initiated by the Regional Director of Plant Operations with all maintenance staff on providing and maintaining reasonable accommodations. Social work in-serviced on room changes with confirmation of room readiness for reasonable accommodations. 4. The Maintenance Director will audit rooms monthly for 3 months to ensure all residents have reasonable accommodation. Results of audits will be reported to the monthly QAPI committee on a monthly basis until the committee determines that the issue is resolved or stable. The results will be used for additional training and system changes if necessary.	

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F 558	Continued From page 2	F 558		

NJ ex order 26.4b1 [redacted]

A review of Resident #37's Quarterly Minimum Data Set (MDS) an assessment tool, indicated that the resident had a brief interview for mental status (BIMS) score of [redacted] out of 15, which indicated that the resident NJ ex order 26.4b1 [redacted] A further review of the MDS revealed that the resident NJ ex order 26.4b1 [redacted]

On 05/31/2024 at 10:26 AM, the surveyor interviewed Certified Nursing Assistant (CNA) #1 who stated Resident #37 NJ ex order 26.4b1 [redacted] When the surveyor asked CNA #1 about the condition of the resident's bathroom, she stated the resident NJ ex order 26.4b1 [redacted]

On 05/31/2024 at 10:34 AM, the surveyor interviewed Licensed Practical Nurse (LPN) #3 who stated she did not know when Resident #37's NJ ex order 26.4b1 [redacted]. LPN #3 stated that the resident NJ ex order 26.4b1 [redacted] LPN #3 stated the resident NJ ex order 26.4b1 [redacted]

On 05/31/2024 at 12:22 PM, the surveyor interviewed the US FOIA (B) (6) [redacted] who stated that US FOIA (b)(6) brought it to his attention last week about Resident #37's bathroom and the

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bathroom should have a pad lock on it since the wall needed to be cut. The US FOIA stated that we locked the resident's bathroom door shut to keep the resident safe. He further stated that the resident could use the tub room bathroom instead.

On 05/31/2024 at 2:25 PM, the US FOIA (B) (6) provided the surveyor with a receipt dated NJ ex order 26.4b1 at 11:26 AM, from a home supply store for materials needed to repair Resident #37's wall.

On 06/03/2024 at 9:13 AM, the surveyor viewed Resident #37's Electronic Health Record (EHR) under the census tab and noted that the resident NJ ex order 26.4b1 on NJ ex order 26.4b1

On 06/03/2024 at 9:56 AM, in a follow up interview with US FOIA (b)(6), he stated NJ ex order 26.4b1 NJ ex order 26. Resident #37 into room #415, but the resident NJ ex order 26.4b1 and required more work than he had anticipated. He stated the work was now in progress since the resident's room had now been changed after surveyor inquiry last Saturday.

On 06/03/2024 at 10:45 AM, the surveyor interviewed Licensed Practical Nurse/Unit Manager (LPN/UM) #4 who stated that the former Unit Manager moved Resident #37 from a semi-private room to a private room. LPN/UM #4 stated that the resident should have been moved from the semi-private room to a room with a bathroom for handwashing and cleanliness.

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LPN/UM #4 stated it was an infection control issue. LPN/UM #4 stated that both the resident and the staff needed the ability to wash. LPN/UM #4 stated she was stumped by the decision to move the resident into that room.

On 06/03/2024 at 12:59 PM, the surveyor interviewed the [US FOIA (B)] who stated that it was an error on behalf of the former [US FOIA (B) (6)] when Resident #37 [NJ ex order 26.4b1] The [US FOIA (B)] stated that the room should have been locked down prior and that was what I believed happened. The [US FOIA (B)] stated, "I was not aware." The [US FOIA (B)] stated he told them the resident had to have a working bath as the wall was crumbling. The [US FOIA (B)] further stated that was not how it should have been, as the resident needed a working bathroom for both privacy and dignity.

On 06/03/2024 at 1:52 PM, the [US FOIA (B)] provided the surveyor with both Open and in Progress Work Orders which indicated that on [NJ ex order 26.4b1], it was noted to be a high priority that the paneling on the wall was coming off and could result in injury to the resident in room [NJ ex or]. On [NJ ex order 26.4b1] a second high priority request was made to Maintenance which indicated there was a hole in the wall behind the resident's door in room [NJ ex ord] There was not documented evidence that the repairs were made when requested.

A review of the facility policy, "Environment of Care" (Last Revised/Reviewed [NJ ex order 26.4b1]) revealed the following:

Policy: To ensure that the facility's buildings, grounds, and equipment are always maintained in a safe and operable manner.

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F 558	Continued From page 5 The facility shall implement a policy to assure that the facility is periodically maintained to assure its effective and efficient operation. Procedure: The Maintenance Department will operate the facility in compliance with current federal, state and local laws, regulations and guidelines that may include, maintaining: The building is in good repair and free from hazards ...The plumbing system is in good working order ...The Maintenance Department will work with facility administration and corporate Facility Services staff to establish priorities for repair and replacement of critical building components of infrastructure. The Maintenance Department will provide and document routine and emergency maintenance service to all areas of the facility. The Maintenance Department will perform other tasks and/or functions that may become necessary or appropriate. A review of the facility policy, "Resident Rights" (Created 05/30/24) revealed the following: ...The resident has a right to a safe, clean, comfortable and Homelike [sic.] environment, including but not limited to receiving treatment and supports for daily living safely.	F 558		
F 584 SS=E	NJAC 8:39-27.1(a), 31.4(a),4.1(a)(12) Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean,	F 584		7/15/24

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comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.

The facility must provide-
§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.
(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.
(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.

§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;

§483.10(i)(3) Clean bed and bath linens that are in good condition;

§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);

§483.10(i)(5) Adequate and comfortable lighting levels in all areas;

§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and

§483.10(i)(7) For the maintenance of comfortable sound levels.
This REQUIREMENT is not met as evidenced by:

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F 584	Continued From page 7 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to keep all areas clean and safe. The deficient practice was identified on 4 of 4 Units ([redacted]NJ Exec Order 26.4b1[redacted] The deficient practice was evidenced by the following: On 05/29/2024 at 10:37 AM during the initial tour of the facility on [redacted]NJ Ex Order 26.4[redacted] the surveyor visited Resident # 5 in their room. At that time, the surveyor observed a trash receptacle. There was not a bag liner in the receptacle. On the other side of the room, a clear trash bag was left on the floor. There was various items of trash within the bag. On the same date at 10:48 AM during the initial tour of the facility on [redacted]NJ Ex Order 26.4[redacted] surveyor # 1 visited Resident # 24 in their room. At that time, the surveyor observed food debris such as crumbs on the floor. The surveyor also observed the bathroom. The surveyor observed that the trash receptacle did not have a bag liner. At that time, Resident # 24 informed the surveyor that the staff does not sweep at all. The trash receptacle was filled with trash at the time of observation. On 06/03/2024 at 9:41 AM, surveyor # 1 visited Resident # 24 in their room. At that time, surveyor # 1 observed a trash receptacle. There was not a bag liner in the receptacle. The trash within the receptacle included but was [redacted]NJ ex order 26.4b1[redacted] The surveyor also observed the bathroom. The surveyor observed that the trash receptacle did not have a bag liner. The trash within the receptacle included but was not limited	F 584	1. Residents #5, #24 and #108's rooms were observed with deficient practice of rooms with broken furniture and the following repairs needed: a) No trash liner, soiled ABD pad b) Rooms not swept for debris c) Stained ceiling tiles d) Hole in wall between wardrobe closets e) Missing nightstand drawer f) Missing/broken blinds g) Ceiling lights not working h) Shower stall missing a curtain i) Sunroom with deteriorated windowsill and door frame w/jagged edges j) Dirty windowsill in dining room k) Pealing wallpaper L) Holes in screens and dirty windows From [redacted]NJ Exec Order 26.4b1[redacted] was discarded, trash can was disinfected, and a new liner was placed. Rooms were swept for debris. Blinds were replaced if in stock or ordered for replacement. Room furniture was repaired or replaced. Lights were replaced. Curtains replaced. Sunroom windowsill and door frame was repaired with drywall and spackle to eliminate jagged edges. Hole in wall was spackled and painted. Wallpaper was ordered. Screens were ordered. Wall panels were ordered. Windowsill and windows were cleaned. 2. All residents may be affected by this deficient practice. 3. On 6/3/2024, a complete audit was conducted on all units to identify furniture that required repair or replacement, light fixtures working, broken blinds, holes in walls, pealing wallpaper, stained ceiling tiles and overall cleanliness of floors to	

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F 584	Continued From page 8 to a NJ Ex Order 26.4b1 . On 06/03/2024 at 11:34 AM during an interview with surveyor # 1, the US FOIA (B) (6) said that rooms are cleaned daily. Secondly, the US FOIA (B included sweeping in her dictation of her expectations from staff when they clean a room. The surveyor asked if trash receptacles should have bag liners. The US FOIA (B replied, "They should." The surveyor asked if NJ Exec Order 26.4b1 be placed in resident room trash receptacles. The US FOIA (B replied, "No, they should not." On 06/05/2024 at 9:54 AM, during an interview with surveyor # 1, the US FOIA (B) (6) confirmed that trash receptacles should have bag liners. Also at that time, the US FOIA (B) (6) confirmed that trash receptacles should have bag liners. Further the US FO clarified that if NJ Exec Order care NJ Exec Order 26.4b1 are in the resident trash receptacles, Housekeeping staff would have to empty and disinfect the can. On 05/29/24 at 10:25 AM during the initial tour of the facility, surveyor # 2 entered room NJ ex or and noted a stained ceiling tile over B bed. The bottom drawer of the resident's night stand was missing. There was a hole in the wall between the two resident's wardrobes. Surveyor # 2 noted that there were no personal effects in the resident's living space. On 05/31/24 at 10:10 AM, surveyor # 2 observed Resident #108 seated in a chair in the dining room. When interviewed, the resident stated	F 584	ensure a homelike environment. Based on findings, maintenance work orders were initiated so repairs, replacements can be scheduled. On 6/5/2004, Maintenance staff and each Department Head and Manager Concierge were re-educated on completing weekly environmental rounds on all room assigned to them so maintenance and housekeeping issues can be addressed immediately that can cause an unhomelike environment for our residents. 4. The Administrator or director/designee will audit five rooms randomly to ensure a homelike environment for our residents weekly for four weeks then monthly for two months to ensure compliance. Results of audits will be reported monthly to the monthly QAPI committee until homelike environment is maintained. The results will be used for additional training and system changes if necessary.	

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he/she moved into room [NJ ex ord] a [NJ Exec Order 26.4b1] The resident stated he/she [NJ Exec Order 26.4b1] about the missing bottom drawer in the nightstand, but had not told anyone about it.

On 05/31/24 at 12:00 PM, surveyor # 2 interviewed CNA #1 who stated Resident #108 recently moved into room [NJ ex ord]. CNA #1 stated she had not noticed the stained ceiling tile over resident's bed, the missing bottom drawer, or broken window blinds. CNA #1 stated the resident [NJ Exec Order 26.4b1] CNA #1 stated we decorated the resident's room if their family brings things in from home. CNA #1 stated she either called housekeeping or [US FOIA (b)(6)] to report needed repairs.

On 05/31/24 at 12:11 PM, surveyor # 2 reviewed the Maintenance Log Book which revealed a written request was placed on 09/12/23, which indicated that the blinds in room [NJ ex ord] were broken and needed to be replaced.

On 05/31/24 at 12:22 PM, surveyor # 2 interviewed the [US FOIA (B) (6)] who stated [NJ ex order 26.4b1]. The [US FOIA] stated he rounded daily. The [US FOIA] stated staff notified [US FOIA (b)(6)] when repairs were needed through an electronic submission. The [US FOIA] stated that maintenance kept supplies on their carts and completed the work as it was received.

On 06/03/24 at 10:17 AM, surveyor # 2 interviewed [US FOIA (b)(6)] in room [NJ ex ord] He stated he was not aware of the stained ceiling tile that was over Resident #108's bed. He stated the stain was related to a roof leak. He stated the roof was repaired, but continued to leak. [US FOIA (b)(6)]

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stated he was notified of the broken blind via electronic submission, but had not gotten around to it. He stated he was also aware of the large stained ceiling tile in entryway of room. He stated the pipe was clamped, but not replaced, and continued to leak. He stated administration came in on Saturday and did walking rounds and replaced the resident's damaged night stand. He stated he recently noted a hole in the sheet rock (wall covering) that was covered by clothing and was previously missed during rounds. He stated the large ceiling tile, blind, and night stand should have been addressed prior, but it was just him here to do all of the work.

On 06/03/24 at 10:59 AM, surveyor # 2 interviewed Licensed Practical Nurse/Unit Manager (LPN/UM) #4 who stated she never saw the stained ceiling tile over Resident #108's bed. She stated it could potentially cause an allergy, as it looked rusty and could turn into mold if it sat too long. She stated the large ceiling tile had leaked in the past and has been reported to US FOIA (b)(6) She stated, "It was not like that when I left." LPN/UM #4 stated the window blinds were reported, and replaced, but she was unsure of which rooms were addressed.

On 06/03/24 at 12:59 PM, surveyor # 2 interviewed the US FOIA (B) (6) who stated if room NJ ex order 2 leak was bad it could leak onto the resident. He stated he was aware the blinds needed replacement, but he did not know there were broken pieces.

On 06/03/24 at 1:52 PM, the US FOIA (B) provided the surveyor with Work Orders that were open and in progress. Review of the Work Orders revealed an

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entry dated [NJ ex order 26.4b1] which indicated "broken furniture, hole in wall, and stained tile, that was entered with high priority."

On 06/04/24 at 10:31 AM, surveyor # 2 interviewed the [US FOIA (B) (6)] who stated if water were to pool in the ceiling tile, then it may present a risk for bacterial growth, but she was not sure and would have to see it. She stated it was more of a safety concern if the ceiling tile pieces were to fall from the ceiling.

On 05/29/2024 at 10:51 AM during initial tour on the pavilion unit, surveyor #3 observed a missing drawer to the dresser in room [NJ ex ord].

On 05/30/2024 at 11:54 AM while touring the pavilion unit surveyor #3 observed, the top drawer from a dresser in room [NJ ex ord] was missing.

On 05/30/2024 at 12:06 PM in the tub room on the [NJ Exec Order 26] Unit surveyor #3 observed, 2 out of 4 ceiling lights were not working, a shower stall missing a shower curtain, brown stains on a ceiling tile in the shower stall and a hole above a call light box. Also, in the bathroom, connected to the tub room the surveyor observed a hole in the wall behind the toilet.

On 05/30/2024 at 12:30 PM in the front sunroom on the [NJ Exec Order 2] unit, surveyor #3 observed, a deteriorated windowsill with exposed rusted metal and rotted wood.

On 05/31/24 at 10:54 AM, in the rear sunroom on the [NJ Exec Order 26] unit, surveyor #3 observed, a deteriorated windowsill with exposed rusted metal, rotted wood, protruding screws and jagged

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edges. The surveyor also observed the door frame, split with jagged edges at the bottom and a broken corner piece.

On 05/31/2024 at 11:10 am during an interview with t surveyor #3, a certified nurse's aide (CNA)#1 said. When asked if it should be exposed, they replied, "No, residents can get hurt." CNA#1 said it should be reported to maintenance.

On 05/31/2024 at 12:22 PM during an interview with surveyor #3, the US FOIA (B) (6) stated, "We do rounds every day. If we see something that needs to be fixed, we load up the cart and fix it that day."
When asked if they had known about the windowsills, the US FOIA (B) (6) stated, "I was notified last week, it needs to be sheet rocked" When asked if it was safe for the resident's they replied, "no".

On 06/04/2024 during an interview with surveyor #3 the US FOIA (B) (6) stated, "No, the drawers should not be missing, windowsills should not be exposed. Residents in that unit destroy things. We are working with US FOIA (b)(6) to be rounding more often and fix what they see having to do with the environment as well."

On 05/30/24 at 8:50 AM during a tour of the NJ Exec Order 25 Unit Room NJ ex order 26 4a, Surveyor #4 observed the following: A broken wall panel at the bottom left of the entrance to the bathroom. A large hole in the panel located against the back wall, which was also noted to be detached from the wall. A large hole in the panel located near the radiator. An opening in the wall near the boarder.

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On 06/04/2024 at 12:15 PM during an interview with Surveyor #4, the US FOIA (B) (6) stated, "No" when asked if he was aware of the damaged panel and damaged wall near the border. The US FOIA also stated "No" when asked should there be holes in the panel and the wall near the border and radiator.

On 06/04/2024 at 12:35 PM during an interview with Surveyor #4, the US FOIA (B) stated "Yes" when asked should the brown panel, wall and boarder be intact.

On 05/31/2024 at 10:10 AM Surveyor # 5 made the following observations on the Court 2 dining/activity room, The window to the left of the stairwell door has\d the wallpaper peeled away. The window to the left of the entry door is not closed completely. All windows are observed to be dirty with a whitish unidentified substance. The lower window adjacent to the activities supply cabinet has an unidentified black/green mold-like substance on the exterior of the lower window, which covers approximately the top 3-4 inches of the window.

On 05/31/2024 at 12:18 PM Surveyor # 5 made the following observations on the Court 2 dining/activity room: The window to the left of the entry door and next to table #9 had unidentified debris in the window sill, including a dead bee. The wallpaper on the left side of the window is peeling away from the wall. The screen on the right side window has an approximate 4 inch x 2 inch hole.

A review of a facility provided document titled, "Housekeeping Daily Routine" revealed that at 8:00 AM housekeeping is expected to, "Walk

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through rooms (policing) Replenish all dispensers inside of rooms, sweep, and remove trash..."

A review of a facility provided document titled, "7-Step Cleaning Process" revealed under number one to, "PULL TRASH, Remove liners and clean inside and outside of the waste receptacle, Reline waste receptacle 3-5 bags per can." The document revealed under number five to, "DUST MOP FLOOR, Dust behind all furniture and doors."

Review of the facility policy, "Maintenance Services" (Policy NO:RF-EC-S-0704) (Last Revised/Reviewed 04/01/24) revealed the following:

The Maintenance Department will operate the facility in compliance with federal, state and local laws, regulations and guidelines that include, maintaining:

The building in good repair and free from hazards. The Maintenance Department will work with the facility administration and corporate Facility Services staff to establish priorities for repair and replacement of critical building components and and infrastructure.

A review of a facility policy titled, Maintenance Services revealed, "To ensure that the facility's buildings, grounds and equipment are always maintained in a safe and operable manner."

A review of the facility provided document titled, "Environment of care." revised on 04/01/2024 under "Procedure" that "1. The Maintenance Department will operate the facility in compliance with current federal, state, and local laws,

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F 584	Continued From page 15 regulations and guidelines that may include, maintaining: The building in good repair and free from hazards." § 8:39-31.4 (a)	F 584		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes.	F 656		7/15/24

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F 656	Continued From page 16 (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Repeat deficiency from the recertification survey of 12/12/2023. Based on observation, interview, review of the medical record and review of other facility documentation, it was determined that the facility failed to develop a comprehensive resident centered care plan for 2 of 35 sampled residents (Resident #28 and Resident #116). This deficient practice was evidenced by the following: 1. During the initial tour on 05/29/2024 at 11:07 AM, Resident #28 was observed lying in bed with the head of the bed elevated. Resident #28 [redacted] A review of the Admission Record revealed Resident #28 was admitted to the facility with diagnoses including but not limited to: [redacted]	F 656	1. Residents #28 and #116 had [redacted] as a result of the deficient practice of incomplete comprehensive care plans. Resident #116 is no longer a patient at the facility. The care plan for resident #28 was immediately updated to include the NJ ex order 26.4b1 [redacted] Unit managers were given individual counseling by the Assistant Director of Nurses on the policy and procedure for Comprehensive Care plans. 2. All residents who utilize ventilators have the potential to be affected by this deficient practice when care plans are not updated to include the resident care needs and person-centered care. Care plans were reviewed and changed as needed. 3. An in-service was done by the Assistant Director of Nurses and corporate Director of Nurses with all	

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F 656	Continued From page 17 NJ ex order 26.4b1 A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate care, dated NJ ex order 26.4b1, indicated Resident #28 had a Brief Interview for Mental Status (BIMS) score of NJ ex /15 indicating Resident #28 NJ ex order 26.4b1. Section NJ ex indicated Resident #28 NJ ex order 26.4b1 while a resident, NJ ex order 26.4b1 A review of the Order Recap Summary dated NJ ex order 26.4b1 revealed the following physician orders: with a start date of NJ ex order 26.4b1 NJ ex order 26.4b1 NJ ex order 26.4b1. Perform assessment of NJ ex order 26.4b1 NJ ex order 26.4b1 NJ ex ord. NJ ex order 26.4b1 . NJ ex order 26.4b1 NJ ex order 26.4b1 . NJ ex order 26.4b1 NJ ex order 26.4b1 . NJ ex order 26.4b1 NJ ex order 26.4b1 NJ ex order 26.4b1 A review of the care plan revealed a FOCUS area: NJ ex order 26.4b1 with Date	F 656	nurses on the policy and procedure for updating and creating Comprehensive Care Plans to include resident centered care needs. 4. The Director of Nurses, Assistant Director of Nurses and Unit managers will audit 10 charts monthly for 3 months to ensure all resident care plans are updated to include resident care needs, appropriate diagnosis, and person-centered care. The results of these audits will be reported to the QAPI committee monthly for 3 months.	

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Initiated: NJ ex order 26.4b1. Under the GOAL section: NJ ex order 26.4b1 Interventions included but were not limited to: NJ ex order 26.4b1 Date Initiated NJ ex order 26.4b1. Nursing staff Obtain labs/diagnostic tests as ordered then notify physician of results with Date Initiated: NJ ex order 26.4b1, Nursing staff NJ Exec Order 2 with Date Initiated: NJ ex order 26.4b1, and NJ ex order 26.4b1 with Date Initiated: NJ ex order 26.4b1.

The care plan did not include documentation or address that Resident #28 NJ ex order 26.4b1

During an interview with the surveyor on 06/03/2024 at 9:19 AM, Unit Manger/Licensed Practical Nurse (UM/LPN #2) was asked who is responsible for doing care plans. UM/LPN #2 responded, "On admission the nurses should do the care plan based on diagnosis and needs of the residents like ADL's (activities of daily living)." The surveyor asked what should be on the care plan. UM/LPN #2 responded any diagnosis, vent, trach, any psychotropic med's, diuretics', antibiotics, Intravenous lines, and ADL's. It should be done on admission, but we have 24 hours. I come in the next day and review it. I make sure they are all updated. Both the nurses and I update the care plans.

On 06/03/2024 at 9:24 AM, the surveyor requested that the UM/LPN #2 UM bring Resident #28's care plan up on the computer screen. UM/LPN #2 confirmed date initiated for the NJ Exec 0 care plan was NJ ex order 26.4b1. The surveyor asked if the NJ Exec 0 care plan was done upon admission. UM/LPN #2 said "No, the NJ Exec 0 care plan was not

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F 656	Continued From page 19 done at time of admission. I did this on Friday." The surveyor then asked UM/LPN #2 if the care plan should have been completed within 24 hours of admission. UM/LPN #2 said, "Yes, it should have been on the care plan upon admission." 2. According to the Admission Record, Resident #116 was admitted to the facility with diagnoses including but not limited to: NJ ex order 26.4b1 [redacted]. According to the most recent MDS dated NJ ex order 26.4b1, Resident #116 had BIMS NJ ex /15. A review of the Order Recap Report dated NJ ex order 26.4b1 revealed the following physician orders: With start date of NJ ex order 26.4b1 [redacted]. NJ ex order 26.4b1 [redacted] NJ ex order 26.4b1 [redacted] #6 NJ ex order 26.4b1 [redacted] A review of the care plan for Resident #116 revealed under FOCUS area with an initiated date of NJ ex order 26.4b1 [Resident name] NJ ex order 26.4b1 [redacted] NJ ex order 26.4b1 [redacted]	F 656		

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GOAL: The resident will have no complications related to NJ ex order 26.4b1 through the review date. Interventions included: Maintain a NJ ex order 26.4b1 by NJ ex order 26.4b1 . NJ ex order 26.4b1 date initiated NJ ex order 26.4b1 Monitor/document changes NJ ex order 26.4b1 with initiated date of NJ ex order 26.4b1.

The care plan did not include documentation that Resident #116 NJ ex order 26.4b1 .

During an interview with the surveyor on 06/03/2024 at 9:19 AM, UM/LPN #2 was asked who is responsible for doing care plans. UM/LPN #2 responded on admission the nurses should do the care plan based on diagnosis and needs of the residents like ADL's (activities of daily living. The surveyor asked what should be on the care plan. UM/LPN #2 responded any diagnosis, vent, trach, any psychotropic meds, diuretics', antibiotics, Intravenous lines, and ADL's. It should be done on admission, but we have 24 hours. I come in the next day and review it. I make sure they are all updated. Both the nurses and I update the care plans.

The surveyor asked UM/LPN #2 to bring up Resident #116's care plan on the computer. On NJ ex order 26.4b1 at 9:26 AM, UM/LPN #2 said Resident #116 was up here before I started. UM/LPN #2 confirmed NJ ex order 26.4b1 NJ ex order 26.4b1 . UM/LPN #2 said "NJ ex order 26.4b1

During an interview with the surveyor on

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F 656	Continued From page 21 06/04/2024 at 10:28 AM, the US FOIA (B) (6) was asked who is responsible to complete a care plan for an admission. The US FOIA (B) (6) responded we have the baseline care plan completed on the day of admission. This could be initiated by the nurse who is admitting the resident. Overall unit managers are in charge of and responsible for care plans. When asked what the process is for readmissions, the US FOIA (B) (6) said it depends on if there is a new problem, if so, we have to update. If a resident had a comprehensive care plan in place and the resident goes out to the hospital, we can update that care plan. The surveyor asked what should be on the care plan. The US FOIA (B) (6) said "Active diagnoses, problems, ADL's, pain, fall, skin, oxygen." When asked if a NJ Exec O should be on the care plan the US FOIA (B) (6) said, "Yes, NJ Exec Order 26.4 should be on the care plan. If NJ Exec Order 26.4 is the primary diagnosis, yes, it should be on the baseline care plan." The US FOIA (B) (6) was unsure of when the comprehensive care plan was to be completed. During a follow up interview on 06/04/2024 at 10:49 AM, the US FOIA (B) (6) said we have 14 days to complete the MDS and 7 days after MDS completed to complete the comprehensive care plan. A review of a facility policy with subject Care Plan with reviewed date of April 2024, revealed under the Policy section: "It is the policy of [facility name] that all residents admitted to the facility will have adequate person-centered care plans that provide for all their needs in a timely manner. Under the Procedure section 2. They will include initial goals, MD (physician) orders, medications, treatments, dietary orders, therapy orders, social services and PASARR recommendations.	F 656		

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F 656	Continued From page 22 NJAC 8:39-11.2(f) Repeat deficiency from the recertification survey of 12/12/2023. Based on observation, interview, review of the medical record and review of other facility documentation, it was determined that the facility failed to develop a comprehensive resident centered care plan for 2 of 35 sampled residents (Resident #28 and Resident #116). This deficient practice was evidenced by the following: 1. During the initial tour on 05/29/2024 at 11:07 AM, Resident #28 was observed lying in bed with the head of the bed elevated. Resident #28 [redacted] A review of the Admission Record revealed Resident #28 was admitted to the facility with diagnoses including but not limited to [redacted] NJ ex order 26.4b1 . A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate care, dated NJ ex order 26.4b1 indicated Resident #28 had a Brief Interview for Mental Status (BIMS) score of [redacted]/15 indicating Resident #28 was NJ ex order 26.4b1 Section [redacted] indicated Resident #28 NJ ex order 26.4b1	F 656		

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NJ ex order 26.4b1

A review of the Order Recap Summary dated NJ ex order 26.4b1 revealed the following physician orders:
with a start date of NJ ex order 26.4b1 NJ ex order 26.4b1:
NJ ex order 26.4b1

NJ ex order 26.4b1

NJ ex order 26.4b1
.
NJ ex order 26.4b1

NJ ex order 26.4b1

NJ ex order 26.4b1

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A review of the care plan revealed a FOCUS area: NJ ex order 26.4b1 [nothing documented] with Date Initiated: NJ ex order 26.4b1. Under the GOAL section: indicated Will maintain a NJ Exec Order 26.4b1 with Date Initiated: NJ ex order 26.4b1. Interventions included but were not limited to: Administer medications/treatments per physician orders with Date Initiated: NJ ex order 26.4b1, Nursing staff Obtain labs/diagnostic tests as ordered then notify physician of results with Date Initiated: NJ ex order 26.4b1 Nursing staff NJ ex order 26.4 with Date Initiated: NJ ex order 26.4b1, and NJ ex order 26.4b1 per protocol with Date Initiated: NJ ex order 26.4b1.

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F 656	Continued From page 24 The care plan did not include documentation or address that Resident #28 NJ ex order 26.4b1, NJ ex order 26.4b1 . During an interview with the surveyor on 06/03/2024 at 9:19 AM, Unit Manger/Licensed Practical Nurse (UM/LPN #2) was asked who is responsible for doing care plans. UM/LPN #2 responded, "On admission the nurses should do the care plan based on diagnosis and needs of the residents like ADL's (activities of daily living)." The surveyor asked what should be on the care plan. UM/LPN #2 responded any diagnosis, vent, trach, any psychotropic med's, diuretics', antibiotics, Intravenous lines, and ADL's. It should be done on admission, but we have 24 hours. I come in the next day and review it. I make sure they are all updated. Both the nurses and I update the care plans. On 06/03/2024 at 9:24 AM, the surveyor requested that the UM/LPN #2 UM bring Resident #28's care plan up on the computer screen. UM/LPN #2 confirmed date initiated for the NJ Exec O care plan was NJ ex order 26.4b1. The surveyor asked if the NJ ex order 26.4b1 was done upon admission. UM/LPN #2 said NJ ex order 26.4b1 The surveyor then asked UM/LPN #2 if the care plan should have been completed within 24 hours of admission. UM/LPN #2 said, "NJ ex order 26.4b1 2. According to the Admission Record, Resident #116 was admitted to the facility with diagnoses including but not limited to: NJ ex order 26.4b1 NJ ex order 26.4b1	F 656		

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F 656	Continued From page 25 According to the most recent MDS dated NJ ex order 26.4b1 Resident #116 had BIMS NJ ex /15. A review of the Order Recap Report dated NJ ex order 26.4b1 revealed the following physician orders: With start date of NJ ex order 26.4b1 NJ ex order 26.4b1 NJ ex order 26.4b1 NJ ex order 26.4b1 A review of the care plan for Resident #116 revealed under FOCUS area with an initiated date of NJ ex order 26.4b1: [Resident name] NJ ex order 26.4b1 . Under GOAL: The resident NJ ex order 26.4b1 through the review date. Interventions included: NJ ex order 26.4b1 . NJ ex order 26.4b1 NJ ex order 26.4b1	F 656		

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The care plan did not include documentation that Resident #116 NJ ex order 26.4b1 [redacted].

During an interview with the surveyor on 06/03/2024 at 9:19 AM, UM/LPN #2 was asked who is responsible for doing care plans. UM/LPN #2 responded on admission the nurses should do the care plan based on diagnosis and needs of the residents like ADL's (activities of daily living. The surveyor asked what should be on the care plan. UM/LPN #2 responded any diagnosis, vent, trach, any psychotropic meds, diuretics', antibiotics, Intravenous lines, and ADL's. It should be done on admission, but we have 24 hours. I come in the next day and review it. I make sure they are all updated. Both the nurses and I update the care plans.

The surveyor asked UM/LPN #2 to bring up Resident #116's care plan on the computer. On NJ ex order 26.4b1 [redacted] at 9:26 AM, UM/LPN #2 said Resident #116 was up here before I started. UM/LPN #2 confirmed there NJ ex order 26.4b1 [redacted] just NJ ex order 26.4b1. UM/LPN #2 said "NJ ex order 26.4b1 [redacted]."

During an interview with the surveyor on 06/04/2024 at 10:28 AM, the US FOIA (B) (6) [redacted] was asked who is responsible to complete a care plan for an admission. The US FOIA (B) (6) [redacted] responded we have the baseline care plan completed on the day of admission. This could be initiated by the nurse who is admitting the resident. Overall unit managers are in charge of and responsible for care plans. When asked what the process is for readmissions, the US FOIA (B) (6) [redacted] said it depends on if there is a new problem, if so, we have to update. If a resident had a

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F 656	Continued From page 27 comprehensive care plan in place and the resident goes out to the hospital, we can update that care plan. The surveyor asked what should be on the care plan. The [redacted] said "Active diagnoses, problems, ADL's, pain, fall, skin, oxygen." When asked if a [redacted] should be on the care plan the [redacted] said, "Yes, [redacted] should be on the care plan. If [redacted] is the primary diagnosis, yes, it should be on the baseline care plan." The [redacted] was unsure of when the comprehensive care plan was to be completed. During a follow up interview on 06/04/2024 at 10:49 AM, the [redacted] said we have 14 days to complete the MDS and 7 days after MDS completed to complete the comprehensive care plan. A review of a facility policy with subject Care Plan with reviewed date of April 2024, revealed under the Policy section: "It is the policy of [facility name] that all residents admitted to the facility will have adequate person-centered care plans that provide for all their needs in a timely manner. Under the Procedure section 2. They will include initial goals, MD (physician) orders, medications, treatments, dietary orders, therapy orders, social services and PASARR recommendations. NJAC 8:39-11.2(f)	F 656		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality.	F 658		7/15/24

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F 658	Continued From page 28 This REQUIREMENT is not met as evidenced by: Based on observation, interviews, review of medical records and other facility documentation, it was determined that the facility failed to follow physician's orders following hospitalization to ensure that a resident who was readmitted to the facility with a NJ Exec Order 26.4b1 [redacted] was scheduled for a follow-up appointment with an US FOIA (B) (6) NJ Exec Order [redacted] and resident US FOIA (B) (6) [redacted]. This deficient practice was identified for 1 of 1 resident (Resident #108) reviewed for a US FOIA (B) (6). This deficient practice was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and	F 658	1. Resident #108 US FOIA (B) (6) [redacted] US FOIA (B) (6) [redacted] The resident US FOIA (B) (6) [redacted] and US FOIA (B) (6) [redacted]. 2. All residents with splints and residents in need of orthopedic appointments have the potential to be affected by this deficient practice of physician orders not being followed with regards to splint usage and not being seen for follow up consultations by orthopedic physician. An audit was conducted to ensure splints ordered are in use and any follow-up appointments scheduled and covered by facility, if necessary. 3. In-servicing was initiated on 6/5/2024 by the Assistant Director of Nurses with nurses on the policy and procedure for following physician orders for splints and setting appointments for orthopedic consultations to include transportation when facility takes Financial responsibility due to resident having no insurance. 4. The Director of Nurses, Assistant Director of Nurses and Unit managers will audit splint orders and usage as well as orthopedic consultations monthly for 3 months to ensure all residents care plans and orders are followed. The results of these audits will be reported to the monthly QAPI committee monthly for 3	

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responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist."

On 05/31/24 at 10:10 AM, the surveyor observed Resident #108 seated in a chair in the dining room. The resident appeared to be [redacted] to [redacted] when spoken to. The resident [redacted] at that time or upon subsequent observations throughout the survey.

Review of Resident #108's Admission Record (an admission summary) revealed that the resident was [redacted] to the facility with diagnosis which included but were not limited to: [redacted]

Review of Resident #108's Significant Change Minimum Data Set (MDS), an assessment tool dated [redacted], revealed the resident had a brief interview for mental status (BIMS) score of [redacted] out of 15 which indicated the resident [redacted].

Review of Resident #108's Care Plan revealed an entry that was revised on [redacted], with a Focus that specified resident presented with a [redacted] and [redacted]. The goal included [redacted]

months.

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NJ ex order 26.4b1, NJ ex order 26.4b1, and NJ ex order 26.4b1. Interventions/Tasks included: NJ ex order 26.4b1 (NJ ex order 26.4b1, NJ ex order 26.4b1 NJ ex order 26.4b1

Further review of Resident #108's Care Plan revealed an entry dated NJ ex order 26.4b1, with a Focus which indicated the resident NJ ex order 26.4b1 NJ ex order 26.4b1. The Goal included resident NJ ex order 26.4b1 NJ ex order 26.4b1). NJ ex order 26.4b1 NJ ex order 26.4b1 ...NJ ex order 26.4b1 NJ ex order 26.4b1.

Review of Resident #108's Order Summary Report (OSR) dated NJ ex order 26.4b1 specified: NJ ex or NJ ex order 26.4b1 with US FOIA (B) (6), NJ ex order 26.4b1 NJ ex order 26.4b1 and NJ ex order 26.4b1 NJ ex order 26.4b1

Review of Resident #108's Progress Notes (PN) revealed an entry dated NJ Exec Order 26 at 12:01 PM, which indicated US FOIA (b)(6) notified this nurse of resident's NJ ex order 26.4b1. NJ ex order 26.4b

Describes NJ ex orde, NJ ex order 26.4b1 ..NJ ex order 26.4b1. On NJ ex order 26.4b1 at 3:40 PM, NJ ex order 26.4b1 results came back. There was NJ ex order 26.4b1 ...A physician's note dated NJ ex order 26.4b1 at 9:47 AM, indicated resident's

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NJ ex order 26.4b1, resident NJ ex order 26.4b1 NJ ex order 26.4b1 NJ ex order 26.4b1 Resident did not report to staff he/she NJ ex order 26.4b1 NJ ex order 26.4b1 NJ ex order 26.4b1. NJ ex order 26.4b1

Further review of the PN revealed that on NJ ex order 26.4b1 at 10:13 PM, resident NJ ex order 26.4b1 NJ ex order 26.4b1. On NJ ex order 26.4b1 at 9:35 PM, resdient NJ ex order 26.4b1 at approximately 8:15 PM. Resident express [sic.] NJ ex order 26.4b1 NJ ex order 26.4b1 [sic.] of shift and return with NJ ex order 26.4b ..Will NJ ex order 26.4b1

Review of Resident #108's hospital Discharge Instructions dated NJ ex order 26.4b1, revealed in the "Brief Summary of Hospital Course and Important Follow Up Information" included... NJ ex order 26.4b1 . NJ ex order 26.4b1 for which NJ ex order 26.4b1. They NJ ex order 26.4b1 and NJ ex order 26.4b1

Further review of the Discharge Instructions revealed the following: NJ ex order 26.4b1 NJ ex order 26.4b1.

Review of Resident #108's facility Incident titled, "NJ ex order 26.4b1 at 8:45 PM, revealed Resident returned to the facility as a readmission with a NJ ex order 26.4b1 NJ ex order 26.4b1

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NJ ex order 26.4b1 ...
Immediate Action Taken:
Orders verified and carried out per hospital instruction as follows:
1. NJ ex order 26.4b1
2. NJ ex order 26.4b1
3. NJ ex order 26.4b1

On 06/03/24 at 11:27 AM, the surveyor interviewed Licensed Practical Nurse/Unit Manager (LPN/UM) #4 who reviewed Resident #108's NJ ex order 26.4b1 in the presence of the surveyor and stated the resident's NJ ex order 26.4b1. The surveyor questioned NJ ex order 26.4b1, as it was not observed on the resident. LPN/UM #4 asked a US FOIA (B) (6) who was present at that time, who stated that resident NJ ex order 26.4b1. LPN/UM #4 further stated that there was no order or indication that the resident NJ ex order 26.4b1

On 06/03/24 11:41 AM, the surveyor interviewed CNA #3 who stated she had not seen Resident #108 NJ ex order 26.4b1

On 06/03/24 at 11:43 AM, in a later interview with LPN/UM #4, she stated in NJ ex order 26.4b1, nursing charted that Resident #108 NJ ex order 26.4b1 NJ ex order 26.4b1. LPN/UM #4 stated on NJ ex order 26.4b1, nursing documented that resident NJ ex order 26.4b1 NJ ex order. LPN/UM #4 stated the NJ ex order 26.4b1 NJ ex order 26.4b1. LPN/UM #4 stated the resident NJ ex order 26.4b1

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NJ ex order 26.4b1, but the rationale should have been documented by the former unit manager. LPN/UM #4 stated, "NJ ex order 26.4b1 and NJ ex order 26.4b1 " LPN/UM #4 stated, "NJ e " The surveyor reviewed the Medication Administration Record (MAR) for NJ ex order 26.4b1 and noted an entry for NJ ex order 26.4b1 NJ ex order 26.4b1 NJ ex order 26.4b1 and NJ ex order 26.4b1 . NJ ex order 26.4b1, NJ ex order 26.4b1 administered NJ ex order 26.4b1) NJ ex order 26.4b1 , NJ ex order 26.4b1, evening shifts: NJ ex order 26.4b1, and NJ ex order 26.4b1. The order was signed as completed on all shifts in NJ ex order 26.4b1 with the exception of evening shift on NJ ex order 26.4b1.

On 06/03/24 at 11:47 AM, the surveyor interviewed the US FOIA (B) (6) in the presence of LPN/UM #4, who stated NJ ex order 26 NJ ex order 26.4b1 US FOIA (B) stated NJ ex order 26.4b1 NJ ex order 26.4 , and the resident NJ ex order 26.4b1 NJ ex order 26.4b1. LPN/UM #4 stated "NJ ex order 26.4b1 NJ ex order 26.4b1 the NJ ex order 26.4b1 and NJ ex order 26.4b1 NJ ex order 26.4b1." The US FOIA (B) agreed to furnish the surveyor with the NJ Ex Order 26.4b1 initial screening.

Review of a Rehabilitation Screen Form dated NJ ex order 26.4b1 revealed the following: Pt screened s/p NJ ex order 26.4b1 secondary to NJ ex order 26.4b1 NJ ex order 26.4b1 . NJ ex order 26.4b1 ... NJ ex order 26 within a week for further instructions, NJ ex order 26.4b1

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NJ ex order 26.4b1. NJ ex order 26.4b1

On 06/03/24 at 11:50 AM, the surveyor interviewed the US FOIA (B) (6) in the presence of LPN/UM #4, who stated Resident #108 was NJ ex order 26.4b1 and NJ ex order 26.4b1. The US FOIA (B) (6) stated she informed the former US FOIA (B) (6) and the US FOIA (B) (6) on NJ ex order 26.4b1. The US FOIA (B) (6) was unable to provide the surveyor with documented evidence of her attempt to schedule the resident to be seen by NJ Exec Order 26.4b1 or notification of the former US FOIA (B) (6) or US FOIA (B) (6) as described.

On 06/03/24 at 12:26 PM, the surveyor interviewed the US FOIA (B) (6) who stated if medically necessary, the facility had to pay and send the resident to their scheduled appointment with transportation. US FOIA (B) (6) stated that she notified the former US FOIA (B) (6) at morning meeting that we were responsible to follow through. US FOIA (B) (6) stated that this was not the first time that she told them that resident NJ ex order 26.4b1. US FOIA (B) (6) stated she was not aware this was still an issue and the resident NJ ex order 26.4b1. US FOIA (B) (6) confirmed that she learned the resident's NJ ex order 26.4b1 on NJ ex order 26.4b1.

On 06/03/24 at 12:42 PM, the surveyor interviewed the US FOIA (B) (6) who stated that the facility would have paid for the cost of the services Resident #108 required and the facility would have been reimbursed by NJ Exec Order 26.4b1 once approved. The US FOIA (B) (6) stated it sounded like they did not follow-up for approval. The US FOIA (B) (6) stated, "there was no way around it, there NJ ex order 26.4b1 for the resident due to either the former

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US FOIA (B) (6), or US FOIA (B) failure to push through and ensure the appointment was made. The US FOIA (B) was unable to provide the surveyor with a policy that pertained to delay in resident treatment when requested.

On 06/03/24 at 1:52 PM, After surveyor inquiry the US FOIA (B) confirmed that Resident #108 was scheduled to for a follow-up appointment with NJ Exec Order 26.4b1 on NJ Exec Order 26.4b at 11:30 AM.

On 06/04/24 at 1:03 PM, the surveyor interviewed the US FOIA (B) (6) who stated if a resident were NJ Exec Order 26.4b1 with NJ Exec Or usage, then staff should encourage use, and if the resident still NJ Exec Order 26 they should have updated the care plan and notified the US FOIA (b)(6) so that the order may have been discontinued.

On 06/04/24 at 01:31 PM, the surveyor interviewed the US FOIA (B) (6) who stated when Resident #108 US FOIA (B) (6) she was asked to screen him/her as the resident NJ ex order 26.4b1 NJ ex order 26.4b1. She stated he/she had an NJ ex order 26.4b1 NJ ex order 26.4b1, and the NJ ex order 26.4b1. She stated the fx NJ ex order 26.4b1, as NJ ex order 26.4b1. She stated that NJ ex order 26.4b1

She stated if a NJ Exec Order 26.4b1 for NJ Exec Order 2 were received NJ Exec Order 26.4b1 follow-up, then we evaluate to see if NJ Exec Order 2 was necessary. She stated a NJ ex order 2 NJ ex order 26.4b1. She described the NJ ex order 26.4b1, and described it as NJ ex order 26.4b1. She further stated the NJ ex order 26.4b1 and NJ ex order 26.4b1

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 36 NJ ex order 26.4 . On 06/05/24 at 10:05 AM, The surveyor interviewed the US FOIA (B) (6) who stated nursing should document NJ ex order 26.4b1 NJ ex ord document removal every shift for NJ Exec O assessment and document refusal if indicated. Review of the facility policy, "Incident and Accident Report and Investigation" (Reviewed April 2024) revealed the following: ...Based on the clinical assessment conducted by the licensed professional nurse, necessary measures will be taken to address the situation in accordance with accepted standards of practice and facility policies. ...All incidents and accidents reported in the facility must be investigated thoroughly to eliminate any possible mishandling and neglect that occurred with the resident. Investigations must be started as soon as the event has been reported and a final disposition/conclusion must be completed accordingly. Review of an undated policy, "Splinting Procedure" revealed the following: ...Nursing staff in-serviced on appropriate application techniques and monitoring requirements specifically associated with equipment (signatures are obtained and a form is placed in patient chart and in therapy binder). NJAC 8:39-27.1 (a),	F 658		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3)	F 690		7/15/24

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F 690	Continued From page 37 §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure that a	F 690	1. Resident #64 had NJ ex order 26.4b1 NJ ex order 26.4b1 because of the NJ ex order 26.4b1	

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F 690	Continued From page 38 resident received appropriate care and sufficient services based upon current standards of practice for a NJ Exec Order 26.4b1. The deficient practice was identified for 1 of 1 residents (Resident # 64) NJ ex order 26.4b1 . This deficient practice was evidenced by the following: On 05/29/2024 at 10:21 AM, during the initial tour of the facility, the surveyor observed Resident # 64 in bed in their room. At that time, the surveyor observed a NJ ex order 26.4b1 NJ ex order 26.4b1 . The NJ ex order 26.4b1 On 05/30/2024 at 11:28 AM, the surveyor observed Resident # 64 in bed in their room. At that time, the surveyor observed the NJ ex order 26.4b1 . The was NJ ex order 26.4b1 A review of Resident # 64's Electronic Medical Record (EMR) revealed under, "Orders" that there was a Physician's Order that indicated, "NJ ex order 26.4b1 " The order was started on NJ ex order 26.4b1 . A review of Resident # 64's Care Plan located in the EMR revealed an intervention for staff to, "NJ ex order 26.4b1 ." That intervention was initiated on NJ ex order 26.4b1. The Care Plan revealed	F 690	and NJ Exec Order 26.4b1 in proper use. The NJ ex order 26.4b1 NJ ex order 26.4b1 on . 2. All residents with urinary catheters have the potential to be affected by this deficient practice of a catheter bag in contact with the floor and no privacy bag in proper use. Audit completed to ensure no catheter bags were touching the floor and all were in privacy bags. 3. On 6/4/2024, inservices were initiated by the Assistant Director of Nurses with nursing staff on the proper use of catheter privacy bags and to ensure no catheter bags are touching the floor 4. The Director of Nurses, Assistant Director of Nurses and Unit managers will audit catheter and privacy bags monthly for 3 months. The results of these audits will be reported to the QAPI committee monthly for 3 months.	

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F 690	Continued From page 39 another intervention for staff to, NJ ex order 26.4b1 and NJ ex order 26.4b1 That intervention was initiated on NJ ex order 26.4b1. On 06/03/2024 at 10:33 AM, during an interview with the surveyor, the US FOIA (b)(6) stated, "It shouldn't NJ Exec Order 26.4b1." after reviewing the surveyor's observations. On 06/05/2024 at 09:54 AM, during an interview with the surveyor, the US FOIA (B) (6) replied, "No" after the surveyor asked if NJ Exec Order 26.4b1 should be in contact with the floor. The US FOIA (B) replied, NJ Exec Order 26.4b1" after the surveyor asked if there was any reason why the NJ Exec Order 26.4b1 should not be in NJ Exec Order 26.4b1 A review of the facility policy titled "Urinary Catheters" dated 04/2024 revealed under procedure that, "6. Do not allow the catheter tubing, bag, or spigot to touch the floor." The policy concludes under "General Information" that, "Residents requiring a urinary catheter are at higher risk for infection." NJAC 8:39-27.1 (a)	F 690		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered	F 695		7/15/24

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F 695	Continued From page 40 care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, review of medical records and other facility documentation, it was determined that the facility failed to ensure: a) NJ Exec Order 26.4b1 was administered to an NJ Exec Order 26.4b1 resident in accordance with physician's orders in a safe and sanitary manner b) residents who were NJ Exec Order 26.4b1 received NJ Exec Order 2 in accordance with professional standards of practice, ensured NJ Exec Order 26.4b1 equipment was properly dated and obtained a physician order for NJ Ex Order 26.4b1. This deficient practice was identified for 2 of 4 residents (Resident #37 and Resident #33) NJ ex order 26.4b1 . This deficient practice was evidenced by the following: 1. During the initial tour of the facility on 05/29/24 at 10:17 AM, the surveyor observed Resident #37 seated in a wheelchair in the dining area. The resident NJ ex order 26.4b1 and NJ ex order 26.4b1 to the resident. On 05/29/24 at 10:19 AM, the surveyor observed a staff member who approached Resident #37 and told the resident he/she NJ ex order 26.4b1 . The staff member then NJ ex order 26.4b1	F 695	1. Resident #37 had no negative outcome due to the deficient practice of an NJ Ex Order 26.4b1, call bell out of reach, and a US FOIA (B) (6) adjusting the NJ Ex Order 26.4b1. Resident #33 NJ ex order 26.4b1 due to the deficient practice of NJ ex order 26 that was not current and dated accordingly. Resident #37 NJ ex order 26.4b1 On NJ ex order 26.4b1, the nurse readjusted the NJ ex order 26.4b1 to the NJ ex order 26.4b1, NJ ex order 26.4b1 and dated it accordingly. 2. All residents utilizing oxygen have the potential to be affected by the deficient practices. Observatioms were made to ensure call bell's are in reach, oxygen cylinders checked to ensure they are not empty, and concentrators settings reviewed and compared to physician orders. Any variances identified were reported to the Director of Nursing. Oxygen tubing was observed, changed, and dated as needed. 3. On 6/5/2024, Assistant Director of Nursing educated the CNAs that call bells must be in reach, oxygen cylinders are not be empty and adjusting oxygen concentrator settings is not in their scope of practice and designated nurses are to adjust to the ordered setting. Nurses were educated to review tubing each Wednesday which will ensure tubing was replaced and dated weekly.	

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F 695	Continued From page 41 NJ ex order 26.4b1 [redacted]. Review of the Admission Record (an admission summary) revealed that the resident was admitted to the facility with diagnosis which included but were not limited to: NJ ex order 26.4b1 [redacted] Review of Resident #37's Quarterly Minimum Data Set (MDS) an assessment tool, indicated that the resident had a brief interview for mental status (BIMS) score of [redacted] out of 15, which indicated that the resident NJ ex order 26.4b1 [redacted] NJ ex order 26.4b1 Review of Resident #37's Order Summary Report revealed an order dated NJ ex order 26.4b1, for NJ ex order 26.4b1 [redacted] Review of Resident #37's Care Plan revealed an entry dated NJ ex order 26.4b1, which indicated the resident NJ ex order 26.4b1 [redacted] The Goal was for the resident	F 695	4. The Director of Nursing or Designee will audit oxygen concentrators and tubing weekly for 12 weeks. Results of these audits will be reported to the monthly QAPI Committee monthly for 3 months.	

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NJ ex order 26.4b1 through the review date NJ ex order 26.4b1 Interventions/Tasks included but were not limited to: NJ ex order 26.4b1 .

On 05/31/24 at 10:22 AM, the surveyor knocked on Resident #37's closed door and entered with resident permission. The surveyor observed Resident #37 lying in bed awake. The surveyor observed the resident NJ ex order 26.4b1 at the bedside. The surveyor NJ ex order 26.4b1 at the foot of the resident's bed that was not in use with NJ ex order 26.4b1 to it that was dated NJ ex order 26.4b1. The resident's NJ ex order 26.4b1 was noted on the floor behind the bed and was out of the resident's reach.

On 05/31/24 at 10:26 AM, the surveyor interviewed Certified Nursing Assistant (CNA) #1 who stated that Resident #37 required minimal assistance to NJ ex order 26.4b1 NJ ex order 26.4b1. CNA #1 stated that when she got here the resident was not in their room and she had not been in the resident's room yet. CNA #1 then proceeded to reach behind the resident's bed and then handed the resident their NJ ex order 26.4b1. CNA #1 stated that if she noted the resident's NJ ex order 26.4b1 she informed the nurse to replace the NJ ex order 26.4b1. CNA #1 observed the NJ ex order 26.4b1 attached to the NJ ex order 26.4b1 and stated that it needed to be refilled. CNA #1 stated I will put the NJ ex order 26.4b1 on the resident now and inform the nurse. CNA #1 then proceeded to NJ ex order 26.4b1

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NJ ex order 26.4b1 and attached it to the NJ ex order 26.4b1 which she attempted to set NJ ex order 26.4b1. The NJ ex order 26.4b1 beeped and a red light flashed with a wrench symbol that flashed off and on and the NJ ex order 26.4b1

On 05/31/24 at 10:34 AM, Licensed Practical Nurse (LPN) #3 entered Resident #37's room. When interviewed, she stated she checked the NJ ex order 26.4b1. LPN #3 looked at the NJ ex order 26.4b1 on the back of the resident's NJ ex order 26.4b1 and confirmed that it was empty. LPN #3 stated that the resident was not supposed to be in bed and NJ ex order 26.4b1. LPN #3 stated she was unaware that the resident was in bed. LPN #3 stated the resident NJ ex order 26.4b1 LPN #3 stated CNA #1 was not supposed to touch the NJ Exec Order 26.4b1 and was instead supposed to let the nurse know. LPN #3 then turned the NJ ex order 26.4b1. The NJ ex order 26.4b1 was dated NJ ex order 26.4b1, according to LPN #3 and was supposed to be changed weekly by night shift. LPN #3 stated that the NJ ex order 26.4b1 LPN #3 stated the resident was last seen on NJ ex order 26.4b1 at 9:15 AM and NJ ex order 26.4b1 on NJ ex order 26.4b1 at that time when the resident received their medications in their NJ ex order 26.4b1. LPN #3 stated that the resident's NJ ex order 26.4b1 LPN #3 further stated that if the resident's NJ ex order 26.4b1 were empty and the NJ ex order 26.4b1 was out of reach that could mean trouble for the resident. LPN #3 then proceeded to bring a

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NJ ex order 26.4b1 into the room and offered to assist the resident into the wheelchair and the resident declined. The resident did not appear to be in immediate distress and attempted to converse with both the LPN #3 and the surveyor. LPN #3 NJ ex order 26.4b1

Review of Resident #37's Treatment Administration Record (TAR) revealed an order for NJ ex order 26.4b1 and NJ ex order 26.4b1.

On 05/31/24 at 2:03 PM, the surveyor interviewed the US FOIA (B) (6) who stated the resident's assigned nurse was responsible for NJ Exec Order 2 function. The US FOIA (B stated the nurse was responsible to place the resident on the Nj ex order 26.4 once the resident was back in bed. The US FOIA (B stated that the aides should not have touched the Nj ex order 26.4b1 because they have to know the liter flow. The US FOIA (B stated the issue was that the resident went Nj ex order 26.4b1 and could not get to the Nj ex order 26.4b1. The US FOIA (B stated the aide should have gotten the nurse immediately and should not have touched the NJ Exec Order 26.4b1 The US FOIA (B stated that Nj ex order 26.4b1 nurse. The US FOIA (B stated that if the Nj ex order 26.4b1 Nj ex order 26.4b1 were dated Nj ex order 26.4b1, it was not changed weekly. The US FOIA (B stated that if nursing documented that the Nj ex order 26 were changed weekly and it was not, then it was false documentation.

On 06/03/24 at 10:45 AM, the surveyor

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interviewed Licensed Practical Nurse/Unit Manager (LPN/UM) #4 who stated staff were supposed to check the Nj ex order 26.4b1 to ensure it was full based on the duration of the tank. LPN/UM #4 questioned why the resident went to bed by themselves. LPN/UM #4 stated that the aide was not allowed to touch the Nj ex order 26.4b because they were not educated on Nj ex order 26.4b1. LPN/UM #4 stated that the Nj ex order 26.4b1

2. During the initial tour on 05/29/24 at 10:07 AM, inside Resident #33's room, the surveyor observed Resident #33 in bed. There was a Nj ex order 26.4b1 Nj ex order 26.4b1 Nj ex order 26.4b1 Nj ex order 26.4b1 The Nj ex order 26.4b1 The Nj ex order 26.4b1 There was no date written on the Nj ex order 26.4b1 and the date on the Nj ex order 26.4b1 Nj ex order 26.4b1 Nj ex order 26.4b1

According to the Admission Record, Resident #33 was admitted to the facility with diagnoses which Nj ex order 26.4b1

Review of Resident #33's Annual Minimum Data Set (MDS) an assessment tool dated Nj ex order 26.4b1

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under section "[redacted] Special Treatments, Procedures, and Programs, it identified that Resident #33 Nj ex order 26.4b1 [redacted]

Review of Resident #33's Care Plan (CP) with an initiation date of Nj ex order 26.4b1 and a revision date of Nj ex order 26.4b1, revealed the following: Focus: Nj ex order 26.4b1 [redacted] Nj ex order 26.4b1 [redacted]

Review of Resident #33's Order Summary Report revealed the following physician order; "Nj ex order 26.4b1 [redacted] There was no order pertaining to Nj ex order 26.4b1 [redacted] Nj ex order 26.4b1

On 05/31/2024 at 01:28 PM, during an interview with the surveyor, the US FOIA (B) (6) [redacted] was present in Resident #33's room and verified that the Nj ex order 26.4b1 [redacted] Nj ex order 26.4b1 was not dated appropriately or according to professional standards of practice. The US FO [redacted] stated that the NJ ex order 26.4b1 should be changed weekly and dated.

On 06/05/2024 at 09:49 AM, during an interview with the surveyor, the Unit Manager (LPN/UM #1) acknowledged that there was no order for Nj ex order 26.4b1 [redacted] and stated that the US FOIA (b)(6) [redacted] would be called.

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F 695	Continued From page 47 Review of the facility policy, "Oxygen Administration" (Revised/Reviewed April 2024) revealed the following: Purpose: To safely administer oxygen to the resident when insufficient oxygen is carried by the blood to the tissues. ...A licensed nurse or other staff person trained in the use of oxygen will be on duty and be responsible for the correct administration of oxygen to the resident. ...At regular intervals, check and clean oxygen equipment, change and label masks, tubing and cannulas weekly. Check resident's respirations and oxygen saturation levels and observe at regular intervals to assess need for further oxygen therapy PRN (as needed) as well as after oxygen has been discontinued. Check physician's order for liter flow and method of administration. Under "Care and Use of Prefilled Disposable Humidifiers," letter I: Label humidifier with date and time opened. Change humidifier and tubing weekly. NJAC 8:39- 19.4(a); 27.1(a), 11.2(b)	F 695		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed	F 755		7/15/24

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F 755	Continued From page 48 personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and pertinent record review, it was determined that the facility failed to ensure the accountability of the narcotic Shift Count logs were completed in accordance with facility policy. This deficient practice was identified for 2 of 4 medication carts reviewed and was evidenced by the following: On 5/30/24 at 9:29 AM, the surveyor, in the presence of the Licensed Practical Nurse (LPN #1), reviewed the "[redacted] nursing unit's	F 755	1. No resident had negative outcome due to the deficient practice of narcotic books missing signatures on 2 units. Nurses working on the dates in question (unsigned) received 1:1 education on importance of counting and signing narcotic book. 2. All residents receiving narcotic medications have the potential to be affected by the deficient practice. All Narcotic books were reviewed to ensure	

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F 755	Continued From page 49 medication cart #1 and the narcotic logbook for that cart. The following was observed: NJ ex order 26.4b1 [redacted] " column and NJ ex order 26.4b1 [redacted] NJ ex order 26.4b1 [redacted] was missing documentation for "Initials" "Cards #" "Bottles #" and "Patches #" At that time LPN #1 confirmed to the surveyor that there should be no pre-signed sections, nor should there be any missing nursing signatures or count documentation for past nursing shift. She stated that the incoming and outgoing nurses are to count the narcotics in the medication cart together and sign the shift log confirming the count at the time the count is completed. On 5/30/24 at 10:51 AM, the surveyor, in the presence of LPN #2, reviewed the "Vent" nursing unit's medication cart #2 and the narcotic logbook for that cart. The following was observed: NJ ex ord [redacted] "Narcotic Book Shift to Shift Signature Sheet" missing a nursing signature for NJ ex order 26.4b1 In" and NJ ex order 26.4b1 [redacted] " and NJ ex order 26.4b1 " columns. At that time LPN #2 stated that every incoming and outgoing nurse should be completing narcotic counts for the medication cart together and signing the shift-to-shift log sheet together for accountability of the narcotic count. LPN #2 further confirmed that if its not documented, it's not done. On 06/04/24 at 9:58 AM, the surveyor interviewed the US FOIA (B) (6) [redacted] who stated that during counts of narcotics, the incoming and outgoing nurses count together and	F 755	no additional missing signatures. None were noted. 3. On 6/6/2024, the Assistant Director of Nursing educated nurses on completed narcotic counts each shift and signing the narcotic book accordingly. The team reviewed narcotic procedures and implemented a streamlined process in which single narcotic count sheets was created to ensure reduction of omissions. 4. The Director of Nursing or Designee will audit narcotic count books weekly for 4 weeks, and then monthly for 3 months. Results of these audits will be reported to the QAPI Committee monthly for 3 months.	

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F 755	Continued From page 50 sign the logs together. The [US FOIA (B) (6)] said the expectation is there should be no missing signatures for previous counts, and there should be no pre-signed for later in the shift or day. A review of the facility's "Controlled Substances" policy with a reviewed/revised date of 1/2024, included, but was not limited to, "nursing staff must count controlled medications at the end of each shift. The nurse coming on duty and the nurse going off duty must make the count together. They must document and report any discrepancies to the Director of Nursing Services." NJAC 8:39-29.7(c)	F 755		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of	F 761		7/15/24

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F 761	Continued From page 51 the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to properly store and properly label opened [NJ Exec Order 26.4b] medications. This deficient practice was identified in 1 of 4 medication carts and 1 of 2 medication storage rooms reviewed for medication storage and labeling and was evidenced by the following: On 5/30/24 at 10:51 AM, the surveyor, in the presence of Licensed Practical Nurse (LPN #2), observed the "[NJ Exec Or] nursing unit's medication cart #2. The following was observed: Three (3) opened prescription fluticasone propionate nasal spray bottles (medication used to treat seasonal allergies), which were not dated with opened date or labeled with resident identifying information on the medication container. At that time LPN #2 stated once multi-dose medications are opened, the nurses are to date the medication container and ensure the resident's name is on it as well as on the outside box or bag it came in. LPN #2 stated this is to ensure proper identification of when the medication was opened and the resident for whom it was prescribed "in case the box and the medication get separated." On 5/30/24 at 11:35 AM, the surveyor, in the	F 761	1. No resident had negative outcomes due to the deficient practice of nasal spray bottles and PPD solution which were not dated with opened date or with no resident identifying information. Any opened medication requiring labeling, including but not limited to nasal sprays and PPD solution, without an open date or resident identifying information were discarded, reordered, and labeled appropriately. 2. All residents have the potential to be affected by the deficient practice of medications that require labeling including but not limited to, nasal spray bottles and PPD solution. Medication carts were audited for any medication requiring labeling including but not limited to open nasal spray and PPD solution without proper labeling. and discarded. 3. On 6/6/2024, The Assistant Director of Nursing educated all nurses on medications requiring labeling after opening including but not limited to nasal spray and PPD solution. 4. The Director of Nursing or Designee will audit and monitor medication carts for proper labeling of any medications including but not limited to nasal sprays and PPD solution weekly for 4 weeks, and then monthly for 3 months. This is in	

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F 761	Continued From page 52 presence of Unit Manager/LPN (UM/LPN #1), observed the "Court 1" nursing unit's medication storage room. The following was observed: One (1) opened and undated vial of tuberculin purified protein (PPD) (a medication used to test for tuberculosis) which was stored in the medication refrigerator. At that time, UM/LPN #1 stated that this medication vial should be dated with the opened date on the medication vial and not just the box as it is possible for the vial to be "mixed into a different box." On 06/04/24 at 9:58 AM, the surveyor interviewed the[US FOIA (B) (6)] who stated that once multi-dose medication containers are opened, expectation is to date it with the date its opened. She further stated that the PPD should have been labeled with the opened date on the vial itself "since it will be used for different people." She explained that the purpose is that some medications have a shorter expiration date than what is labeled from the manufacturer once it is opened. A review of the facility's "Storage of Medications" policy with a reviewed/revised date of 1/2024, included but was not limited to: "Policy statement: the facility shall store all drugs and biologicals in a safe, secure, and orderly manner." Furthermore, the policy included: "drug containers that have missing, incomplete, improper, or incorrect labels shall be returned to the pharmacy for proper labeling before storing. The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed."	F 761	addition to monthly routine inspections by Pharmacist Consultant. Results of these audits will be reported to the monthly QAPI Committee monthly for 3 months.	

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F 761	Continued From page 53 N.J.A.C. 8:39-29.4	F 761		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of other pertinent facility documents, it was determined that the facility failed to handle potentially hazardous foods and maintain sanitation in a safe and consistent manner to prevent food borne illness. This deficient practice was evidenced by the following: On 05/29/2024 from 09:32 to 10:06 AM, the surveyor, accompanied by the interim US FOIA (B) (6) observed the following in the kitchen:	F 812	1. On 5/29/2024, the open bag of frozen pancakes was discarded, and the dented can was removed from dry storage and placed in the designated area for dented cans. On 5/30/2024, the walk-in refrigerator fan cover was cleaned. On 6/3/2024, bleach was pulled from storage and used to sanitize all dishes by rewashing and sanitizing before the following meal service. Sanitizing solution was refilled and extra/backup supply was obtained. The dietary aide operating the dish machine was educated, and a	7/15/24

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F 812	Continued From page 54 1. In the dry storage area of the kitchen on a middle shelf an opened bag of rainbow pasta had no open or use by date. The bag had a hole in it and was exposed to contamination. The [US FOIA] removed the pasta from the dry storage. 2. In the rear of the walk-in freezer an opened box of frozen pancakes and an opened box of frozen French Toast slices were placed on top of milk crates. The boxes were opened, and the pancakes and French Toast were exposed to contamination. The [US FOIA] removed the exposed products from the walk-in freezer. 3. Upon entry to the walk-in refrigerator the surveyor observed an excessive amount of dust-like debris on the fan guard on the roof of the walk-in refrigerator. The [US FOIA] stated, "I contacted maintenance last week to come clean it." The surveyor asked the [US FOIA] if it was verbal or formal communication. The [US FOIA] replied, "I think the administrator told maintenance to clean it. It was verbal communication." 4. On a middle shelf of what the [US FOIA] described as the "freezer" an opened box contained frozen breaded chicken patties. Inside the box a plastic bag was previously opened, and the chicken patties were exposed. The [US FOIA (6] agreed that the product should not be exposed to contamination. The product was removed from the freezer. On 05/31/2024 from 10:25 to 10:35 AM, the surveyor, accompanied by the Unit Manager/Licensed Practical Nurse (UM/LPN #3) mad the following observation in the Court 2 Pantry: 1. The surveyor opened the lid to the ice machine	F 812	competency on all dietary staff was completed on 6/5/2024. All ice machines were cleaned. 2. All residents may be affected by this deficient practice. 3. An audit was conducted on 5/29/2024 for dented cans in dry storage and open bags in the freezers. An audit was conducted on 6/4/2024 on dish machine sanitization and refrigerator fan cleanliness to ensure that the facility is compliant with the requirements. Any items found during the audit were corrected immediately. Dietary staff started education on 6/3/2024 on the facility policies and procedures on dry storage, storage of food items in freezers, cleanliness of refrigerator fans, and dish machine sanitization and infection control. Nurses and Housekeeping were educated on maintaining clean and sanitized ice machines. 4. The Dietary Director/designee will audit dry storage areas for dented cans, refrigerators for fan cover cleanliness, freezers for open food items, and dish machines PPM testing checked and recorded prior to running the dish machine and ice machine cleanliness weekly for 4 weeks then monthly for two months to ensure compliance. Results of audits will be reported to the QAPI committee monthly until the committee determines that the issue is resolved or stable. The results will be used for additional training and system changes if necessary.	

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in the Court 2 pantry, which was used for residents residing on Court 2. The scoop was stored external. Upon inspection of the interior of the ice machine the surveyor observed a brown/green/black substance on the bottom of the white drip ledge above the clean ice supply. The surveyor used their right index finger and applied pressure in a scraping motion on the lower edge of the drip ledge. Once the surveyor removed their finger the right index finger had a green/brown slimy substance on it. The surveyor showed the UM/LPN #3 their finger who agreed that the ice machine was dirty and needed cleaning. When asked who was responsible for the cleaning of the ice machine UM/LPN #3 stated that maintenance cleans the machine and that it was done about a month ago. I'm not really sure who does what.

On 05/31/2024 from 10:37 to 10:53 AM, the surveyor, accompanied by UM/LPN #1 observed the following on Court 1 pantry:

1. In a cabinet above the sink area on the top shelf the surveyor observed an opened plastic bottle of "Refresher Antibac Foam (an antimicrobial hand wash)." The label on the bottle stated, "For external use only." The lid was removed, and the product was exposed. The Antibac foam was stored in the same cabinet as multiple single serve cold cereal packages, hand towels, artificial sweeteners (sweet' n low), sugar packets, and coffee mate. In addition, a plastic take-out style container with a clear plastic lid was next to the Antibac foam on the upper shelf. The container had a sticky note on it that stated a name (illegible) and a date of "12/9/23." There was dried food debris in the container and a metal fork. On interview the UM/LPN #1 stated,

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"No you can't store chemicals and food together. I know that." UM/LPN #1 removed the take-out container to the trash and removed the Antibac foam from the cabinet in the presence of the surveyor.

On 05/31/2024 at 12:33 PM, the surveyor conducted an interview with the facility US FOIA (B) (6) [redacted]. The US FOIA (B) provided the surveyor with the following information when asked who was responsible for the ice machine maintenance. The US FOIA (B) stated, "I'm almost finished cleaning the ice machine. I clean them every 3 months. In fact. it was due to be cleaned next month. I'll provide you with a copy of the schedule." The US FOIA (B) provided the surveyor with a schedule of cleaning for the Court 2. The documentation indicated that the Court 2 fixed ice machine was cleaned on December 29, 2023, and last cleaned on March 28, 2024. The next scheduled cleaning was to be completed June of 2024.

On 06/03/2024 at 10:27 AM, the surveyor entered the facility kitchen while dish washing was actively taking place. The surveyor approached the US FOIA (B) (6) The surveyor asked if the dish machine that was in operation was a low temperature or high temperature dish machine. The US FO stated it was a "low temperature" dish machine. The surveyor asked what chemical was being utilized for sanitation. The US FO stated, "I don't know. We ran out." The surveyor asked the US FO if he was running the dish machine without any chemical sanitizer. The US FO stated, "Yeah, we ran out. They know about it; they said just wash the dishes anyway." The US FO then pointed to the empty 5-gallon bucket under the dish machine that was to hold the chlorine sanitizer. The bucket

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was observed to be empty and confirmed to be empty by the surveyor picking up the bucket and looking into the opening on top of the bucket. The bucket had no chlorine. The surveyor then observed the machine wash temperature at 150 degrees Fahrenheit (F). The rinse temperature was observed to be 140 F. Rinse temperature must be 180 F or greater for heat sanitization.

On 06/03/2024 at 10:35 AM, the surveyor conducted an interview with the US FOIA (B) (6). The surveyor asked the interim US FOIA if she was aware that dish washing was being performed without chemical sanitizer with a low temperature dish machine. The interim US FOIA stated, "I was made aware that there was no sanitizer for the dish machine this AM. Yes, I am aware that we washed the dishes without sanitizer."

A review of the June 2024 "Dish Machine Ware Washing - Low Temperature" log the following was documented prior to dish washing at breakfast on June 3rd: Wash Temp: 135 F, Final Rinse Temp: 145 F, Chlorine Sanitizer PPM (parts per million): US FOIA (B) (6) was asked to obtain a chlorine test strip to assess the chlorine level of the dish machine. A plastic pellet bottom was placed on a plastic dish rack and was sent through the dish machine for an entire wash and rinse cycle. Upon exiting the dish machine, the US FOI obtained a white chlorine test strip and placed it on the wet pellet lid. The test strip remained white in color, which indicated 0 ppm of chlorine.

On 06/03/2024 at 10:43 AM, the US FOIA was able to obtain liquid bleach from the housekeeping department. The 5-gallon chlorine bucket was observed to be approximately one quarter full.

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The surveyor observed the US FOIA again place a plastic pellet bottom on a rack and run the rack through the dish machine for a full wash and rinse cycle. Upon the rack exiting the dish machine the US FOIA again obtained a white chlorine test strip and placed the test strip against the wet pellet base. The white test strip turned deep purple in color indicating that the chlorine level is 50-100ppm, sufficient for sanitization. The US FOI went on to explain, "We ran out this morning. Santec (a foodservice service company) was here Friday and had to replace the nozzles on the machine.". When asked who is responsible for ensuring that the facility has an adequate supply of sanitizer the US FOIA stated, "The dietary manager is responsible for ordering the chemicals, but she just took over a week ago." The US FOIA instructed kitchen staff to re-wash and sanitize all dishes that went through the dish machine prior to obtaining a satisfactory chlorine level.

On 06/03/2024 at 10:55 AM, the surveyor conducted an interview with the facility US FOIA (B) (6) . Upon telling the US FOIA (B) that the facility was washing dirty dishes and utensils used to serve resident meals without sanitizer for the low temperature dish machine the US FOIA (B) responded, US FOIA (B) (6) told me that he tested the chlorine level this morning at 60 ppm. We ran out when the breakfast dishes were being done. We borrowed from house keeping and we are now going to re-wash and sanitize all dishes that went through the machine to ensure that they are properly sanitized."

On 06/06/2024 from 9:52 to 10:12 AM, the surveyor, accompanied by the US FOIA and the US FOIA (b)(6) made the following observations in the

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F 812	Continued From page 59 kitchen: 1. On a bottom shelf of the reach-in refrigerator a quarter pan contained grape jelly. The grape jelly had plastic wrap that only partially covered it and the grape jelly was exposed. The US FOIA removed the grape jelly from the refrigerator and instructed the interim US FOIA to throw it away in the presence of the surveyor. The surveyor reviewed the facility policy titled Food Storage, undated. The following was revealed under the PROCEDURES heading: 5. Chemicals must be clearly labeled, kept in original containers when possible, and kept in a locked area away from food. 13. Food is stored a minimum of 6 inches above the floor on clean racks, dollies, or other clean surfaces, and is protected from splash, overhead pipes, or other contamination. 15. Leftover food is stored in covered containers or wrapped carefully and securely. Each item is clearly labeled and dated before being refrigerated. Leftover food is used within 48 hours or discarded. 17. Freezer Temperatures: e. Rewrap packages of frozen food which have been opened. This prevents freezer burns and spoilage. The surveyor reviewed the facility policy titled Dishwasher Temperature, Date Reviewed/Revised: 3/24/24. The following was revealed under the heading Policy:	F 812		

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F 812	Continued From page 60	F 812		

"It is the policy of this facility to ensure dishes and utensils are cleaned under sanitary conditions through adequate dishwasher temperatures."

In addition, the policy further revealed the following under Policy Explanation and Compliance Guidelines:

4. For low temperature dishwashers (chemical sanitization):

a. The wash temperature shall be 120 F.

b. The sanitizing solution shall be 50 ppm (parts per million) hypochlorite (chlorine) on dish surface in final rinse.

The surveyor reviewed the facility policy titled Food Brought in from outside sources, undated. The following was observed under the heading Procedure:

4. Staff will monitor resident's room, unit pantry, refrigerator/freezer units for food and beverage for disposal.

The surveyor reviewed the facility provided 'PM - Special Duty Cleaning" list for May 12, 19, and 26th of 2024. The special duty cleaning list for Sunday through Saturday failed to address cleaning of the fan in the walk-in refrigerator/freezer.

The surveyor reviewed the facility provided Food Service Closing Checklist for May 19, and May 26th, 2024. The closing checklist started on Sunday and ended on Monday. The Food Service Closing Checklist failed to address cleaning of the

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F 812	Continued From page 61 fan in the walk-in refrigerator/freezer. The surveyor reviewed the facility provided "A.M. SHIFT DAILY CLEANING LIST" dated June 1, June 2, and June 3/2024. The cleaning list failed to address the cleaning of the fan in the walk-in refrigerator/freezer. NJAC 18:39-17.2(g)	F 812		
F 836 SS=C	License/Comply w/ Fed/State/Locl Law/Prof Std CFR(s): 483.70(a)-(c) §483.70(a) Licensure. A facility must be licensed under applicable State and local law. §483.70(b) Compliance with Federal, State, and Local Laws and Professional Standards. The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. §483.70(c) Relationship to Other HHS Regulations. In addition to compliance with the regulations set forth in this subpart, facilities are obliged to meet the applicable provisions of other HHS regulations, including but not limited to those pertaining to nondiscrimination on the basis of race, color, or national origin (45 CFR part 80); nondiscrimination on the basis of disability (45 CFR part 84); nondiscrimination on the basis of age (45 CFR part 91); nondiscrimination on the basis of race, color, national origin, sex, age, or disability (45 CFR part 92); protection of human	F 836		7/15/24

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F 836	Continued From page 62 subjects of research (45 CFR part 46); and fraud and abuse (42 CFR part 455) and protection of individually identifiable health information (45 CFR parts 160 and 164). Violations of such other provisions may result in a finding of non-compliance with this paragraph. This REQUIREMENT is not met as evidenced by: Based on interview, and review of other facility documentation, it was determined that the facility failed to notify CMS (Centers for Medicare & Medicaid Services) and apply for a change in name to include Doing Business As in accordance with 42 CFR (Code of Federal Regulations) 424.516. This deficient practice was evidenced by the following: According to 42 CFR 424.516 Additional provider and supplier requirements for enrolling and maintaining active enrollment status in the Medicare Program: "(a) Certifying compliance. CMS enrolls and maintains an active enrollment status for a provider or supplier when that provider or supplier certifies that it meets, and continues to meet, and CMS verifies that it meets, and continues to meet, all of the following requirements: (1) Compliance with title XVIII of the Act and applicable Medicare regulations. (2) Compliance with Federal and State licensure, certification, and regulatory requirements, as required, based on the type of services, or supplies the provider or supplier type will furnish and bill Medicare. (3) Not employing or contracting with individuals or entities that meet either of the following conditions: (i) Excluded from participation in any Federal	F 836	1. No resident had negative outcomes due to the deficient practice of the facility using a doing business as (dba) name of The Grove at Cherry Hill. The facility will refrain from using that name and will revert all official documents and marketing materials back to Silver Healthcare Center. 2. No residents were affected by the deficient practice. 3. The Executive Director and Administrator agreed to exclusively use the current facility name of Silver Healthcare Center until a change of ownership is pursued and approved. 4. The Executive Director and Administrator will change all official documentation and marketing materials to Silver Healthcare Center. Any items changed will be submitted to the monthly QAPI Committee monthly for 3 months.	

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F 836	Continued From page 63	F 836		

health care programs, for the provision of items and services covered under the programs, in violation of section 1128 A(a)(6) of the Act.
(ii) Debarred by the General Services Administration (GSA) from any other Executive Branch procurement or nonprocurement programs or activities, in accordance with the Federal Acquisition and Streamlining Act of 1994, and with the HHS Common Rule at 45 CFR part 76.....
(d) Reporting requirements for physicians, nonphysician practitioners, and physician and nonphysician practitioner organizations.
Physicians, nonphysician practitioners, and physician and nonphysician practitioner organizations must report the following reportable events to their Medicare contractor within the specified timeframes:
(1) Within 30 days -
(i) A change of ownership;
(ii) Any adverse legal action; or
(iii) A change in practice location.
(2) All other changes in enrollment must be reported within 90 days."

A review of the facility Admission agreement and arbitration agreement, revealed under the facility name section as "The Grove Center for Rehabilitation and Healthcare." A review of the Arbitration Agreement also part of the admission packet indicated, "This agreement is optional for residents and The Grove at Cherry Hill." The Business cards provided to the surveyors upon entrance reflected the facility name as "The Grove at Cherry Hill."

During an interview with the surveyor on 5/31/2024 at 12:00 PM, the facility [redacted] and the

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F 836	Continued From page 64 US FOIA (B) (6) said they never applied for a NJ ex order 26.4b1 The US FO said we are still Silver Health as on the license but for marketing we use "The Grove" and the community knows us as "The Grove." The surveyor indicated the admission agreements and arbitration agreements have "The Grove" name as well and the US FO said, "That is an easy change to make." The US FO also said, "They are Doing Business As (DBA) so we can use both names but have not done an 855 B form." A review of the facility license that was issued by the New Jersey Department of Health Division of Certificate of Need and Licensing with an issue date of NJ ex order 26.4b1, and an expiration date of NJ ex order 26.4b1. The NJDOH issued the license for the facility name of Silver Healthcare Center, not The Grove or The Grove at Cherry Hill. NJAC 8:39-5.1 (a)	F 836		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880		7/15/24

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F 880	Continued From page 65 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F 880		

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F 880	Continued From page 66 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to a) adhere to accepted standards of infection control practices for the proper storage of NJ ex order 26.4b1 after use, and b) perform proper hand hygiene during NJ Exec Order 26.4b1 care treatment. This deficient practice was observed for 2 of 4 residents (Resident #33 and Resident #42) reviewed for NJ ex order 26.4b1. This deficient practice was evidenced by the following: a.) During the initial tour of the facility on 05/29/2024 at 10:07 AM, the Surveyor #1 observed Resident #33 in his/her bedroom, lying in bed. Surveyor #1 observed a NJ ex order 26.4b1 [redacted] NJ ex order 26.4b1 [redacted] . NJ ex order 26.4b1 . On 05/30/2024 at 09:07 AM, Surveyor #1 observed Resident #33's NJ ex order 26.4b1 [redacted],	F 880	1. Resident #33 and resident #42 had NJ Ex [redacted] as a result of the deficient practice of; a. NJ ex order 26.4b1 [redacted] NJ ex order 26.4b1 b. NJ ex order 26.4b1 [redacted] c. US FOIA (B) (6) who failed to perform hand hygiene after removing gloves. Respiratory Therapist #1 received re-education on hand hygiene after removing gloves and equipment stored properly. 2. All residents receiving respiratory treatments including need for suctioning have the potential to be affected by these deficient practices. Rounds and observations were competed to ensure staff were using proper hand hygiene when removing gloves. Respiratory equipment was stored correctly. 3. Infection Preventionist educated the US FOIA (b)(6) and nurses on proper hand hygiene and equipment	

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F 880	Continued From page 67 uncovered, directly touching the inside of the bottom drawer. On 05/31/2024 at 08:16 AM, Surveyor #1 observed Resident #33's NJ ex order 26.4b1 of the bedside table, NJ ex order 26.4b1 A review of the Admission Record medical record Resident #33 was admitted with a diagnosis that included but not limited to, NJ ex order 26.4b1. The medical record also revealed that the resident had [redacted] and NJ ex order 26.4b1 On 05/31/2024 at 1:28 PM, during an interview with Surveyor #1, the US FOIA (B) (6) who was present in Resident #33's room, was questioned as to whether the NJ ex order 26,4b1 was stored properly. At that time, the [redacted] observed the NJ Exec Order 26.4b1 lying in the bottom drawer of the bedside table, uncovered, open to air, touching other items in drawer. The [redacted] responded, "[redacted], the NJ ex order 26,4b1. That is an infection control concern. It should be stored in a NJ ex order 26,4b1 of the client." 06/03/24 at 10:28 AM, during an interview with Surveyor #1, the Respiratory Therapist (RT #1) was questioned as to the procedure for [redacted] NJ ex order 26,4b1 RT #1 responded, "it's not a sterile procedure, but is clean. After NJ ex order 26,4b1, the NJ ex order 26,4b1 sleeve and then into a bag." RT #1 added that the care of NJ ex order 26,4b1 is based on	F 880	storage. Competency on hand hygiene was completed with Respiratory Therapist with satisfactory return demonstration. 4. Infection Preventionist will complete rounds 2x weekly for 4 weeks and weekly thereafter for 60 days to ensure all staff perform hand hygiene after changing gloves, use of trash liners, equipment stored properly, dated tubing, catheters off the floor and cleaning of ice machines. The results of these audits will be reported to the QAPI committee monthly for 3 months.	

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F 880	Continued From page 68	F 880		

standards of care and policy.

06/03/24 10:41 AM, during an interview with Surveyor #1, the Unit Manager/Licensed Practical Nurse (UM/LPN#1) was questioned as to the proper care of NJ ex order 26,4b1. The UM/LPN #1 stated that it is based on facility policy. The UM/LPN #1 verified that the storage of suctioning equipment after each use is to be stored in the NJ ex order 26,4b1.

A review of a policy provided by the facility titled, "Suctioning: Oral," with a revised date of 1/2024, revealed under procedure: Once the Yankauer is out, flush it through with water to remove secretions and place the packaging back on to keep it clean.

b.) A review of Resident #42's Admission Record indicated the resident was admitted to the facility with diagnosis which included but was not limited to: NJ ex order 26,4b1 NJ ex order 26,4b1 NJ ex order 26,4b1

A Review of the resident's quarterly Minimum Data Set (MDS) a comprehensive assessment tool dated NJ Exec Orde, indicated Resident #42 had a Brief Interview for Mental Status (BIMS) score of NJ ex out of 15 indicating the resident was NJ ex order 26,4b1.

A review of the physician's orders included an order with start date of NJ ex order 26,4b for NJ ex order 26,4b1 NJ ex order 26,4b1

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F 880	Continued From page 69 A review of the Resident #42's NJ ex order 26,4b1 [redacted].	F 880		

On 06/04/2024 from 11:30 AM to 11:38 AM, Surveyor #2 observed RT #2 perform NJ ex order 26,4b1 for Resident #42. The following was observed:

At 11:31 AM, RT #2 approached the resident's room door where there was a bin outside the room door containing disposable personal protective equipment including, disposable gowns, gloves, masks, and a bottle of alcohol-based hand rub (ABHR) (sanitizing solution used for hand hygiene). After performing hand hygiene with the ABHR, RT #2 donned (put on) a clean gown and gloves and proceeded to obtain a disinfectant wipe and entered the resident's room to wipe down the bedside tray table in preparation to place the NJ ex order 26,4b1 care products. After wiping the table, RT #2 disposed of the sanitizing wipe, doffed (took off) the gloves and disposed of them as well. She then went back to the bin outside the resident's room, obtained new clean gloves, and without using ABHR or any other form of hand hygiene, donned the new gloves and brought in the NJ ex order 26,4b1 supplies and placed them on a NJ Exec Order 26,4b1 which she placed on the recently sanitized tray table. She then proceeded with the ordered NJ ex order 26,4b1.

At 11:39 AM, Surveyor #2 interviewed RT #2 and inquired about hand hygiene in between the glove change. RT #2 stated it was not necessary as her

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F 880	Continued From page 70 procedure she follows does not indicate it. RT #2 provided Surveyor #2 with a copy of this document titled "Advantage Respiratory Care Services Policy Procedure Manual 'Tracheostomy care, decannulation, suctioning, cuff care, weaning trial methods/procedures'" with a revised date of October 15, 2016. When asked if this is the most up to date revision and how often this policy and procedure is reviewed and revised, RT #2 stated she was unsure. On 06/04/2024 at 11:48 AM, Surveyor #2 interviewed the [redacted], who stated that all the residents on the [redacted] unit are on an [redacted] depending on their individual diagnosis, and that hand hygiene should be done upon entering and exiting the resident's rooms as well as in between all glove changes. The surveyor inquired about the policy and procedure document provided by RT #2, to which the [redacted] reviewed and stated, "this is an old policy," and respiratory care should be done "following the updated policy." The [redacted] stated she would provide Surveyor #2 with the most current and updated policy that is to be followed. A review of the facility's undated "Hand Hygiene Policy and Procedure" document provided by the IP included but was not limited to: under the section titled "Indications for alcohol based hand rub" included use of ABHR "after contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient," and "after removing gloves." NJAC 8:39-19.4 (a) (1, 2)	F 880		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2)	F 883		7/15/24

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F 883	Continued From page 71 §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is	F 883		

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F 883	Continued From page 72 medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to ensure that the NJ Ex Order 26.4b1 was offered to all residents upon admission to the facility to prevent incidence of NJ Exec Order 26.4b1 for 1 of 5 residents (Resident #100) reviewed for NJ Exec Order 26.4b1 administration. This deficient practice was evidenced by the following: On 05/29/2024 at 10:44 AM, during the initial tour of the facility, the surveyor observed Resident #100 NJ ex order 26.4b1 NJ ex order 26.4b1. When interviewed, the resident was NJ Ex Order 26.4b1 how the NJ ex order 2 occurred. A review of Resident #100's Admission record revealed that the resident was admitted to the facility with diagnosis which included but were not limited to: NJ ex order 26.4b1	F 883	1. Resident #100 had NJ ex order 26.4b1 he responsible party for resident #100 NJ ex order 26.4b1 NJ ex order 26.4b1 and the NJ ex order 26.4b1 2. All residents had the potential to be affected by the deficient practice of missing immunization consents. An audit was conducted to ensure that all residents have consents in their medical record for all administered vaccinations. 3. The Resident Pneumoccocal policy was reviewed. In-service education was initiated on 6/5/2024 for Nurses, Unit Managers, and Supervisors n the need to have a signed consent from either the resident or responsible party prior for administering immunizations. 4. The Infection Preventionist or designee will audit the medical record of 5	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315280	A. BUILDING _____ B. WING _____	C 06/05/2024

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 DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 DEFICIENCY)	(X5) COMPLETION DATE
F 883	Continued From page 73 NJ ex order 26.4b1. A further review of the Admission Record revealed that the resident had NJ ex order 26.4b1. A review of Resident #100's immunization status within the Electronic Health Record (EHR), revealed an NJ ex order 26.4b1 NJ ex order 26.4b1 NJ ex order 26.4b1 A review of Resident #100's Annual Minimum Data Set (MDS), an assessment tool, revealed that the resident NJ ex order 26.4b1. A further review of the MDS revealed that the resident's NJ ex order 26.4b1, as resident was determined to be NJ ex order 26.4b1 due to an unspecified NJ ex order 26.4b1. On 05/31/2024 at 11:45 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) # 3 who reviewed Resident #100's NJ Exec Order 26.4b1 status in the presence of the surveyor in the EHR. LPN #3 stated that the resident required consent to receive the NJ ex order 26.4b1. LPN # 3 further stated that she was unsure who was responsible to obtain consent for NJ Exec Order 26.4b1 administration. LPN #3 further stated that she knew that "it was definitely not the nurse's responsibility to obtain consent for NJ Exec Order 26.4b1 administration." On 05/31/2024 at 11:48 AM, the surveyor interviewed the US FOIA (b)(6) who stated Resident #100 should have been offered the NJ ex order 26.4b1 upon admission to the facility. The US F stated the resident's family	F 883	residents per week for 90 days to ensure all administered vaccinations have signed consent forms. The results of these audits will be reported to the monthly QAPI committee monthly for 3 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315280	A. BUILDING _____ B. WING _____	C 06/05/2024

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 DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 DEFICIENCY)	(X5) COMPLETION DATE
F 883	Continued From page 74	F 883		

member was required to sign consent on behalf of the resident if the resident was deemed to be NJ Exec Order 26.4b1. The [redacted] reviewed Resident #100's EHR and stated that the NJ ex order 26.4b1 [redacted] t. The [redacted] stated that either the US FOIA (B) (6), US FOIA (B) (6) or the [redacted] was responsible to follow-up to ensure consent was obtained. The [redacted] further stated there was currently no Unit Manager assigned to the nursing unit.

On 06/04/2024 at 8:23 AM, in a later interview with the [redacted], she stated that Resident #100 did not receive the NJ ex order 26.4b1 upon admission to the facility as consent was not obtained on behalf of the resident. The [redacted] confirmed that after surveyor inquiry, the resident's responsible party was contacted, and the resident received the NJ ex order 26.4b1 [redacted] The [redacted] further stated that she was unsure why the consent was not completed timely, as the need for consent should have come up on a check list on three subsequent shifts following admission for supervisor review to ensure completion.

A review of a facility policy titled, "Pneumococcal Immunization Vaccine" (Revised 03/2024) revealed the following:

All residents shall be offered pneumococcal vaccines to aide in preventing pneumonia/pneumococcal infections.

Prior to or upon admission, residents shall be assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, shall be offered the vaccine series

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 DEFICIENCY)	(X5) COMPLETION DATE
F 883	Continued From page 75 within thirty (30) days of admission to the facility unless medically contraindicated or the resident has already been vaccinated. Assessments of pneumococcal vaccination status shall be conducted within five (5) working days of the resident's admission if not conducted prior to admission. ...Pneumococcal vaccines shall be administered to residents (unless medically contraindicated, already given, or refused) per the facility's physician-approved pneumococcal vaccination protocol. ...Administration of the pneumococcal vaccines or revaccinations shall be made in accordance with current Centers for Disease Control and Prevention (CDC) recommendations at the time of vaccination. NJAC 8:39-19.4 (h) (i)	F 883		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060407	A. BUILDING: _____ B. WING _____	C 06/05/2024

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

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S 000	Initial Comments Complaint #: NJ 169959, 172797, 172731, 172664, 173098, 173137, 173170, 173420, 173499, 173568, 173837, 173857, 174044. The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficieny and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, enforcement of licensure regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Complaint #NJ173420 Based on interview, and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff-to-resident ratios for the day shift as mandated by the State of New Jersey. This was evident 14 of 56 days shifts. The deficient practice was evidenced by the following: Reference: New Jersey Department of Health	S 560	1. No residents were affected by not meeting the State of NJ minimum staffing requirements as determined by routine monitoring and review on those dates that no significant changes were noted. 2. All residents could be affected by not meeting State of NJ minimum staffing requirements. 3. Recruitment and retention efforts continue to include: a. Job fairs b. Daily staffing meetings and weekly Regional Labor Management reviews	7/15/24

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

Electronically Signed | 06/21/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 560	Continued From page 1 (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. "Direct care staff member" means any registered professional nurse, licensed practical nurse, or certified nurse aide who is acting in accordance with that individual's authorized scope of practice and pursuant to documented employee time schedules. The following ratio(s) were effective on 02/01/2021: One CNA to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. As per the "Nurse Staffing Report" completed by the facility for the weeks of Complaint staffing and, 2 weeks of staffing prior to survey from 03/31/2024 to 05/25/2024, the facility was deficient in CNA staffing for residents on 14 of 56 day shifts as follows: -03/31/24 had 12 CNAs for 111 residents on the day shift, required at least 14 CNAs.	S 560	c. Training mentor program to support retention d. Culture committee to improve and maintain staff morale e. Recruitment bonus and sign-on bonuses offered. f. Completive wage analysis 4. To monitor and maintain ongoing compliance the Director of Nursing or designee will monitor staffing daily for 1 week, weekly for 3 weeks and monthly for 3 months. Results will be presented to the Quality Assurance and Performance Improvement team monthly for continued review and recommendations until substantial compliance is maintained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 560	Continued From page 2 -04/14/24 had 13 CNAs for 115 residents on the day shift, required at least 14 CNAs. -04/15/24 had 12 CNAs for 114 residents on the day shift, required at least 14 CNAs. -04/18/24 had 12 CNAs for 112 residents on the day shift, required at least 14 CNAs. -04/20/24 had 13 CNAs for 112 residents on the day shift, required at least 14 CNAs. -04/21/24 had 11 CNAs for 112 residents on the day shift, required at least 14 CNAs. -04/27/24 had 13 CNAs for 114 residents on the day shift, required at least 14 CNAs. -04/28/24 had 10 CNAs for 114 residents on the day shift, required at least 14 CNAs. -04/29/24 had 11 CNAs for 117 residents on the day shift, required at least 15 CNAs. -05/05/24 had 9 CNAs for 116 residents on the day shift, required at least 14 CNAs. -05/10/24 had 13 CNAs for 118 residents on the day shift, required at least 15 CNAs. -05/11/24 had 14 CNAs for 117 residents on the day shift, required at least 15 CNAs. -05/12/24 had 14 CNAs for 117 residents on the day shift, required at least 15 CNAs. -05/13/24 had 14 CNAs for 117 residents on the day shift, required at least 15 CNAs.	S 560		

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S 560	Continued From page 3 On 06/04/2024 at 12:22 PM, during an interview with the surveyor, the Staffing Coordinator replied, "Yes" when asked if she is aware of the state-mandated minimum staffing requirements. On the same date at 12:35 PM, during an interview with the surveyor, the Licensed Nursing Home Administrator (LNHA) replied, "Yes" when asked if the facility is aware of the state mandate regarding CNA staffing. During the same interview, the LNHA replied, "most days we are" when asked if the facility was meeting the requirements. A review of the facility policy titled Nursing Staff, revealed "POLICY The facility will maintain staffing requirements at or above the prescribed nursing ratio as described in the New Jersey Staffing requirements for long term care. The facility will try to utilize all resources to maintain the proper staffing ratios."	S 560		
S1405	8:39-19.5(a) Mandatory Infection Control and Sanitation a) The facility shall require all new employees to complete a health history and to receive an examination performed by a physician or advanced practice nurse, or New Jersey licensed physician assistant, within two weeks prior to the first day of employment or upon employment. If the new employee receives a nursing assessment by a registered professional nurse upon employment, the physician's or advanced practice nurse's examination may be deferred for up to 30 days from the first day of employment. The facility shall establish criteria for determining the completeness of physical examinations for employees.	S1405		7/15/24

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S1405	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on interview, and review of other facility documentation, it was determined that the facility failed to ensure that employees received an examination by a Physician, an Advanced Practice Nurse, or a Licensed Physician Assistant within two weeks prior to the first day of employment or upon employment. The deficient practice was evident for 4 of 10 employees reviewed under the Sufficient and Competent Nurse Staffing task and was evidenced by the following: On 06/03/2024 at 10:00 AM, the surveyor reviewed the employee files of ten random and recently hired employees. Employee # 2 was hired on NJ ex order 26.4b1. On the bottom of the Confidential Employee's Medical History, under the section (TO BE COMPLETED BY A PROVIDER) the line next to Provider's Signature and Date was blank. Employee #4 was hired on NJ ex order 26.4b1. On the bottom of the Confidential Employee's Medical History, under the section (TO BE COMPLETED BY A PROVIDER) the line next to Provider's Signature and Date was blank. Employee #8 was hired on NJ ex order 26.4b1. On the bottom of the Confidential Employee's Medical	S1405	1. No residents were affected by physician signature missing from 4 of 10 new employee physicals in the employee health records. The Medical Director was called to schedule review of the records missing signature. On 6/4/2024, the Medical Director was on-site and recognized his error of omission and corrected the 4 of 10 missing signatures. 2. All residents could be affected by the deficient practice. 3. Regional Human Resources Director educated the facility Human Resources Director on completion of employee health records. 4. To monitor and maintain ongoing compliance the Human Resources Director will review new employee health records monthly for 3 months. Results will be presented to the monthly Quality Assurance and Performance Improvement team monthly for continued review and recommendations until substantial compliance is maintained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S1405	Continued From page 5 History, under the section (TO BE COMPLETED BY A PROVIDER) the line next to Provider's Signature and Date was blank. Employees #10 was hired on [NJ ex order 26.4b1]. On the bottom of the Confidential Employee's Medical History, under the section (TO BE COMPLETED BY A PROVIDER) the line next to Provider's Signature and Date was blank. On 06/03/2024 at approximately 12:20 PM, during an interview with Surveyor, the Licensed Nursing Home Administrator replied "Yes" when asked is it fair to say that the physical was not completed if it was not signed. The LNHA also replied "Yes" when asked should it had been completed. A review of a policy provided by the facility titled "Evaluations/Physicals" revealed, "The [facility Name] personnel will all be checked for baseline health assessment on hire, including immunization status."	S1405		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315280 Y1	A. Building B. Wing Y2	7/17/2024 Y3

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 F0558	Correction	ID Prefix F0584	Correction	ID Prefix F0656	Correction
Reg. # 483.10(e)(3)	Completed	Reg. # 483.10(i)(1)-(7)	Completed	Reg. # 483.21(b)(1)(3)	Completed
LSC	07/15/2024	LSC	07/15/2024	LSC	07/15/2024
ID Prefix F0658	Correction	ID Prefix F0690	Correction	ID Prefix F0695	Correction
Reg. # 483.21(b)(3)(i)	Completed	Reg. # 483.25(e)(1)-(3)	Completed	Reg. # 483.25(i)	Completed
LSC	07/15/2024	LSC	07/15/2024	LSC	07/15/2024
ID Prefix F0755	Correction	ID Prefix F0761	Correction	ID Prefix F0812	Correction
Reg. # 483.45(a)(b)(1)-(3)	Completed	Reg. # 483.45(g)(h)(1)(2)	Completed	Reg. # 483.60(i)(1)(2)	Completed
LSC	07/15/2024	LSC	07/15/2024	LSC	07/15/2024
ID Prefix F0836	Correction	ID Prefix F0880	Correction	ID Prefix F0883	Correction
Reg. # 483.70(a)-(c)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. # 483.80(d)(1)(2)	Completed
LSC	07/15/2024	LSC	07/15/2024	LSC	07/15/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
6/5/2024	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
060407	A. Building B. Wing	7/17/2024

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

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 07/15/2024	ID Prefix S1405 Reg. # 8:39-19.5(a) LSC	Correction Completed 07/15/2024	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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	
6/5/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
060407 Y1	A. Building B. Wing Y2	7/17/2024 Y3

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

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 07/15/2024	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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	
6/5/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315280	A. BUILDING **01, 02, 03** B. WING _____	C **06/05/2024**

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 DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 06/03/2024 and 06/04/2024, and Silver Healthcare Center was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy This building was identified as the "Atrium Building" (#1) and is a single-story building, Type V protected construction. The Atrium Building #1 has 38 Resident sleeping rooms with common areas that Residents, Visitors and Staff could use. The census in the Atrium Building #1 was 0 at the time of survey. The building is divided into 3 smoke zones.	K 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 06/03/2024 and 06/04/2024, and Silver Healthcare Center was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy This building was identified as the "Pavilion Building" (#2) and is a single-story building, Type	K 000		

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

Electronically Signed | 06/21/2024

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K 000	Continued From page 1 V protected construction. The Pavilion Building #2 has 22 Resident sleeping rooms with common areas that Residents, Visitors and Staff could use. The census in the Pavilion Building #2 was 26 at the time of survey. The building is divided into 3 smoke zones.	K 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 06/03/2024 and 06/04/2024, and Silver Healthcare Center was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy This building was identified as the "Court Building" (#3) and is a Two-story building, Type II protected construction. The Court Building #3 is made up of Court #1 (first floor) which has 37 Resident sleeping rooms and common areas and Court #2 (second floor) which has 33 Resident sleeping rooms. There is a "Vent Unit" on the second floor with 8 Resident sleeping rooms. The census in the Court #1 building first floor was 37 Residents at the time of survey. The census in the Court #2 building second floor was 47 at the time of survey. The census in the Vent Unit second floor was 7 Residents at the time of survey. The Court Building #3 is divided into 6 smoke zones.	K 000		

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K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and review of facility provided documentation on 06/03/2024 and 06/04/2024 in the presence of facility management, it was determined that the facility failed to ensure that fire-rated doors to hazardous areas were self-closing, and were separated by	K 321	1. No residents experienced negative outcomes as a result of the deficient practice of a storage room and office without a self-closer. The self-closer was present but detached. This was immediately corrected on 6/3/2024 (photo	7/15/24

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K 321	Continued From page 3 smoke resisting partitions in accordance with NFPA 101, 2012 Edition, Section 19.3.2.1, 19.3.2.1.3, 19.3.2.1.5, 19.3.6.3.5, 19.3.6.4, 8.3, 8.3.5.1, 8.4, 8.5.6.2 and 8.7. This deficient practiced was evidenced by the following: On 06/03/2024 (day one of survey) during the survey entrance at approximately 9:20 AM, a request was made to the US FOIA (B) (6) US FOIA (B) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is three (3) buildings that are connected. The Atrium (#1), the Pavilion (#2) and the Court (#3) buildings. Starting at approximately 9:41 AM on 06/03/2024 and continued on 06/04/2024, in the presence of the facility US FOIA, a tour of the building was conducted. Along the two (2) day tour of the facility, the surveyor observed the following hazardous area that failed to have smoke resisting doors, 1.) On 06/04/2024 at approximately 10:40 AM, an inspection of the second floor Court Building (#3) Vent Unit was performed. The surveyor observed that the corridor door leading into the Respiratory Supply room identified as #321 automatic door closure had been disconnected. The surveyor also observed a sign on the corridor door that read, "Respiratory Supply Room please keep door closed at all times Thank You."	K 321	attached). 2. All residents have the potential to be affected by these deficient practices. Doors were observed to ensure self-closers were present, if required. Corrective measures taken, as necessary. 3. Maintenance staff were re-educated on proper monitoring and maintaining doors that require self-closers. 4. Maintenance Director will audit doors requiring self-closers monthly x3 months. Any violations will be corrected immediately. The results of these audits will be reported monthly to the monthly QAPI committee until sustained substantial compliance is met.	

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K 321	Continued From page 4 The surveyor observed inside the supply room, several combustible cardboard boxes and other combustible products being stored on open shelving in the room. The storage room was larger than 50 square feet. A review of an emergency evacuation diagram posted in the corridor identified you the room is in the primary and or secondary exit access path to reach an exit. With the not self-closing into its frame, this would allow fire, smoke and poisonous gases to pass into the exit access corridor in the event of a fire. The [US FOIA] confirmed the findings at the time of observations. The US FOIA (b)(6) and US FOIA (B) (6) were informed of the deficiency during the survey exit on 06/04/2024 at approximately 2:20 PM. NJAC 8:39-31.2 (e) Life Safety Code 101	K 321		
K 324 SS=E	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke	K 324		7/15/24

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K 324	Continued From page 5 compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observation on 06/03/2024, in the presence of the US FOIA (b)(6) it was determined that the facility failed to ensure that 1 of 5 exhaust hood grease baffles were in the proper position to protect against grease and fire from entering above the exhaust hood system as per NFPA 96. This deficient practice was evidenced by the following: Reference: NFPA 96 19.3.2.5.3* (10) Procedures for the use, Inspection, Testing, and Maintenance of the cooking equipment are in accordance with Chapter 11 of NFPA 96 and the Manufacturers instructions and are followed. On 06/03/2024 at approximately 11:10 AM, the surveyor observed in the kitchen that 1 of 5 kitchen hood grease baffles were not properly installed over the main commercial cooking stove	K 324	1. No residents experienced negative outcomes as a result of the deficient practice of a gap between hood plates (Exhaust Hood Grease Baffles) in the kitchen. The gap was immediately corrected on 6/3/2024. 2. All residents have the potential to be affected by these deficient practices. All kitchen hood plates were observed to ensure no gaps were present. Corrective measures taken, as necessary. 3. Dietary staff were re-educated on proper monitoring and maintaining kitchen hood vents with no gaps. 4. Food Service Director will audit kitchen hoods for any gaps weekly x4 weeks and monthly x3 months. Any violations will be corrected immediately. The results of these audits will be reported monthly to the monthly QAPI committee until sustained substantial	

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K 324	Continued From page 6 in the following location: The grease baffle from the right-side was not properly set in the track. The surveyor observed, measured and recorded a 4 inch wide by 17 inch high opening to the exhaust ventilation system. The Grease baffles are the first layer of protection in a commercial kitchen's grease management and exhaust ventilation system. Their purpose is to prevent flames and flammable debris from entering the exhaust duct and capture grease-laden vapors produced from cooking equipment. If this grease were not captured, it would build up in the ventilation system and become a significant fire hazard. The [US FOIA] confirmed the findings at the time of observations. US FOIA (B) (6) were informed of the deficiency during the survey exit on 06/04/2024 at approximately 2:20 PM.	K 324	compliance is met.	
K 363 SS=D	NJAC 8:39-31.2(e) NFPA 96, 19.3.2.5.3*(10) Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors	K 363		7/15/24

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K 363	Continued From page 7 to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and review of facility provided documentation on 06/03/2024 and 06/04/2024, in the presence of facility management, it was determined that the facility failed to ensure that 2 of 21 corridor doors observed and inspected in the "Atrium Building #1", were able to resist the passage of smoke in accordance with the requirements of NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3,	K 363	1. No residents experienced negative outcomes as a result of the deficient practice of a gap greater than 1 at the bottom of doors in: a) Atrium building: i) Room #340 ii) Storage room across from SPS room These items were corrected on 6/5/2024 with fire rated materials to eliminate	

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K 363	Continued From page 8 19.3.6.3.1 and 19.3.6.5. This deficient practice was evidenced by the following: On 06/03/2024 (day one of survey) during the survey entrance at approximately 9:20 AM, a request was made to the US FOIA (b)(6) [redacted] to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified there are three (3) buildings that are connected together, the Atrium Building (#1), the Pavilion Building (#2) and the Court Building (#3). The Atrium Building #1 has 43 Resident sleeping rooms, the Pavilion Building #2 has 23 Resident sleeping rooms and the Court Building #3 has 82 Resident sleeping rooms. Starting at approximately 9:41 AM on 06/03/2024 and continued on 06/04/2024, in the persence of the facility [redacted] a tour of the 3 buildings was conducted. The surveyor observed, measured and recorded the following corridor doors in the Atrium Building #1, On 06/04/2024: 1. At approximately 1:05 PM, the surveyor measured and recorded a 1/4 inch gap along the top edge of the Resident room #340 corridor door. This would allow fire, smoke and poisonous gases to pass into the exit access corridor in the event of a fire. 2. At approximately 1:14 PM, the surveyor	K 363	excess gaps to <1". 2. All residents have the potential to be affected by these deficient practices. All doors have been observed to ensure no gaps are present and latching mechanisms present and working properly. Corrective measures taken, as necessary. 3. Maintenance staff were re-educated on proper monitoring and maintaining doors with no gaps and with proper latching mechanisms. 4. Maintenance Director will audit doors for any gaps and working latching mechanisms monthly x3 months. Any violations will be corrected immediately. The results of these audits will be reported monthly to the monthly QAPI committee until sustained substantial compliance is met.	

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K 363	Continued From page 9 measured and recorded a 1-1/4 inch gap along the bottom edge of a storage room across from the SPS room. This would allow fire, smoke and poisonous gases to pass into the exit access corridor in the event of a fire. Code requires doors protecting corridoors have gaps no larger than 1/8 of an inch around the doors frame and no more than one (1) inch along the doors bottom edge. The [redacted] confirmed the findings at the times of observations. [redacted] were informed of the deficiency during the survey exit on 06/04/2024 at approximately 2:20 PM. NJAC 8:39-31.1(c), 31.2(e) NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5.	K 363		
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material.	K 363		7/15/24

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K 363	Continued From page 10 Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: REPEAT DEFICIENCY from 12/12/2023 survey Based on observation and review of facility provided documentation on 06/03/2024 and 06/04/2024, in the presence of facility management it was determined that the facility failed to ensure that 5 of 35 corridor doors observed and inspected in the "Court Building #3", were able to resist the passage of smoke in accordance with the requirements of NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5. This deficient practice was evidenced by the	K 363	1) No residents experienced negative outcomes as a result of the deficient practice of a gap greater than 1 at the bottom of doors in: a) Pavilion and Court buildings rooms: (1) 133 (2) 132 (3) EVS office (4) 134 (5) Shower room across from room 115 Corrections were made on 6/5/2024 (photo attached) 2) All residents have the potential to be affected by these deficient practices. All	

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SILVER HEALTHCARE CENTER	**1417 BRACE ROAD** **CHERRY HILL, NJ 08034**

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K 363	Continued From page 11 following: On 06/03/2024 (day one of survey) during the survey entrance at approximately 9:20 AM, a request was made to the US FOIA (B) (6) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified there are three (3) buildings that are connected together, the Atrium Building (#1), the Pavilion Building (#2) and the Court Building (#3). The Atrium building #1 has 43 Resident sleeping rooms, the Pavilion building #2 has 23 Resident sleeping rooms and the Court building #3 has 82 Resident sleeping rooms. Starting at approximately 9:41 AM on 06/03/2024 and continued on 06/04/2024, in the presence of the facility US FOIA a tour of the 3 buildings was conducted. The surveyor observed, measured and recorded the following corridor doors in the Court Building #3: On 06/04/2024 Court Building first floor: 1. At approximately 11:20 AM, the surveyor measured and recorded a 1-5/16 inch gap along the bottom edge of the Resident room #133 corridor door. This would allow fire, smoke and poisonous gases to pass into the exit access corridor in the event of a fire. 2. At approximately 11:22 AM, the surveyor measured and recorded a 1-1/2 inch gap along the bottom edge of the Resident room #132 corridor door.	K 363	doors have been observed to ensure no gaps are present and latching mechanisms present and working properly. Corrective measures taken, as necessary. 3) Maintenance staff were re-educated on proper monitoring and maintaining doors with no gaps and with proper latching mechanisms. 4) Maintenance Director will audit doors for any gaps and working latching mechanisms monthly x3 months. Any violations will be corrected immediately. The results of these audits will be reported mpnthly to the monthly QAPI committee unitl sustained substantial compliance is met.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315280	A. BUILDING **01, 02, 03** B. WING _____	C **06/05/2024**

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 DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 DEFICIENCY)	(X5) COMPLETION DATE
K 363	Continued From page 12 This would allow fire, smoke and poisonous gases to pass into the exit access corridor in the event of a fire. 3. At approximately 11:35 AM, the surveyor measured and recorded a 1/4 of an inch gap along bottom edge of the Environmental Services Office corridor door. This would allow fire, smoke and poisonous gases to pass into the exit access corridor in the event of a fire. 4 At approximately 11:36 AM, the surveyor measured and recorded a 1-1/2 inch gap along the bottom edge of the Resident room #134 corridor door. This would allow fire, smoke and poisonous gases to pass into the exit access corridor in the event of a fire. 5. At approximately 11:37 AM, the surveyor measured and recorded a 1-1/4 inch gap along the bottom edge of the Shower room (across from Resident room #115) corridor door. This would allow fire, smoke and poisonous gases to pass into the exit access corridor in the event of a fire. Code requires doors protecting corridors have gaps no larger than 1/8 of an inch around the doors frame and no more than one (1) inch along the doors bottom edge. The [redacted] confirmed the findings at the times of observations. [redacted] were informed of the deficiency during the survey exit on 06/04/2024 at approximately 2:20 PM.	K 363		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315280	A. BUILDING **01, 02, 03** B. WING _____	C **06/05/2024**

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 DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 DEFICIENCY)	(X5) COMPLETION DATE
K 363	Continued From page 13 NJAC 8:39-31.1(c), 31.2(e) NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5.	K 363		
K 372 SS=D	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 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: Based on observations and review of facility provided documentation on 06/03/2024 and 06/04/2024, in the presence of facility management, it was determined that the facility failed to maintain the integrity of smoke barrier partitions for one (1) of eight (8) smoke/fire barrier walls inspected. This deficient practice was evidenced by the following: On 06/03/2024 (day one of survey) during the survey entrance at approximately 9:20 AM, a request was made to the US FOIA (B) (6) US FOIA (B) to provide a copy of the facility lay-out	K 372	1. No residents experienced negative outcomes as a result of the deficient practice of smoke barrier penetrations on court-2 smoke barrier door on b-wing above the ceiling. The penetrations were corrected on 6/3/2024. 2. All residents have the potential to be affected by these deficient practices. Smoke barriers were observed for penetrations. Corrective measures taken, as necessary. 3. Maintenance staff were re-educated on proper monitoring and maintaining smoke barriers free of penetrations. 4. Maintenance Director will audit smoke	7/15/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315280	A. BUILDING **01, 02, 03** B. WING _____	C **06/05/2024**

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 DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 DEFICIENCY)	(X5) COMPLETION DATE
K 372	Continued From page 14 which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is three (3) buildings that are connected. The Atrium (#1), the Pavilion (#2) and the Court (#3) buildings with twelve (12) smoke barrier walls in the three (3) buildings. Starting at approximately 9:41 AM on 06/03/2024 and continued on 06/04/2024 in the presence of the facility [redacted] a tour of the building was conducted. Along the two (2) day tour of the facility the surveyor observed the following smoke barrier wall failed to maintain the 1/2 hour fire rated construction as required by code in the following location; On 06/04/2024: At approximately 9:34 AM, the surveyor observed in the "Court Building" #3 second floor going into "B-Wing", above the ceiling tiles of the corridor double smoke doors the smoke barrier wall had three (3) approximately 1//2 inch diameter penetrations through the wall with one RED wire running the the penetration. At that time the surveyor observed and confirmed above the ceiling tiles on the other side of the double smoke doors three (3) approximately one inch in diameter penetrations through the smoke barrier wall with the same RED wire running through the wall. These penetrations were observed on both sides through the smoke barrier wall, indicating that it was not sealed closed to prevent smoke, fumes and fire from passing through to the other smoke compartment. The [redacted] confirmed the findings at the time of	K 372	barriers monthly x3 months. Any violations will be corrected immediately. The results of these audits will be reported to the monthly QAPI committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315280	A. BUILDING **01, 02, 03** B. WING _____	C **06/05/2024**

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 DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 DEFICIENCY)	(X5) COMPLETION DATE
K 372	Continued From page 15 observations. US FOIA (B) (6) were informed of the deficiency during the survey exit on 06/04/2024 at approximately 2:20 PM. NJAC 8:39- 31.2(e).	K 372		
K 521 SS=E	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: REPEAT DEFICIENCY from the 12/12/2023 survey. Based on observations on 06/03/2024 and 06/04/2024 in the presence of facility management, it was determined that the facility failed to ensure that the facility's ventilation systems were being properly maintained for 3 of 5 Resident bathroom exhaust systems in the Pavilion Building #2, as per the National Fire Protection Association (NFPA) 90A. This deficient practice was evidenced by the following: On 06/03/2024 (day one of survey) during the	K 521	1. Residents in rooms NJ ex order 26.4b1 and NJ ex ord had no negative outcome as a result of the deficient practice of non-working ventilation system. The ventilation units were repaired on 6/3/2024 (photo attached). 2. All residents have the potential to be affected by these deficient practices. Rounds and observations were completed to ensure all rooms have working ventilation systems. Corrective measures taken, as necessary. 3. Maintenance staff were re-educated on proper monitoring and preventative maintenance of ventilation systems for resident rooms.	7/15/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315280	A. BUILDING **01, 02, 03** B. WING _____	C **06/05/2024**

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 DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 DEFICIENCY)	(X5) COMPLETION DATE
K 521	Continued From page 16 survey entrance at approximately 9:20 AM, a request was made to the US FOIA (B) (6) US FOIA (B to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. The surveyor also asked how many Resident sleeping rooms are in the facility. The US FOIA didn't know how many Resident sleeping rooms were in the facility. A review of the facility provided lay-out identified the facility is three (3) buildings that are connected. The Atrium (#1), the Pavilion (#2) and the Court (#3) buildings. Starting at approximately 9:41 AM on 06/03/2024 and continued on 06/04/2024, in the presence of the facility US FOIA, a tour of the building was conducted. During the tour of the Pavilion Building #2, the surveyor inspected five (5) Resident sleeping room bathrooms. This inspection identified when the bathroom exhaust systems were tested (by placing a piece of single ply tissue paper across the grills to confirm ventilation is present), the exhaust did not function properly in 3 of 5 resident bathrooms in the following locations: 1. At approximately 9:54 AM, in the Pavilion building Resident room #412 bathroom, when tested the exhaust system did not function properly. This bathroom had no window with an area that would open. This bathroom would rely on mechanical ventilation. 2. At approximately 9:56 AM, in the Pavilion building Resident room #413 bathroom, when tested the exhaust system did not function properly. This bathroom had no window with an area that would open. This bathroom would rely	K 521	4. Maintenance will audit ventilation systems for one unit each week and repeated every 4 weeks for three months. Any violations will be corrected immediately. The results of these audits will be reported to the QAPI committee monthly for 3 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315280	A. BUILDING **01, 02, 03** B. WING _____	C **06/05/2024**

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

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K 521	Continued From page 17 on mechanical ventilation. 3. At approximately 10:00 AM, in the Pavilion building Resident room #[NJ ex (B)] bathroom, when tested the exhaust system did not function properly. This bathroom had no window with an area that would open. This bathroom would rely on mechanical ventilation. The [US FOIA] confirmed the findings at the time of observations. The US FOIA (B) (6) were informed of the deficiency during the survey exit on 06/04/2024 at approximately 2:20 PM. NFPA 90A. NJAC 8:39- 31.2 (e).	K 521		
K 911 SS=D	Electrical Systems - Other CFR(s): NFPA 101 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: Based on observation on 06/03/2024 and 06/04/2024, in the presence of facility management, it was determined that the facility failed to ensure that 1 of 9 electrical outlets located next to a water source (with-in 6 feet) was equipped with Ground-Fault Circuit Interrupter (GFCI) protection as required.	K 911	1. No residents experienced negative outcomes as a result of the deficient practice of 1 of 9 outlets within 6 inches of a sink without a GFI. The GFI outlet in the rehab gym was added on 6/4/2024 (photo attached). 2. All residents have the potential to be	7/15/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315280	A. BUILDING **01, 02, 03** B. WING _____	C **06/05/2024**

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 DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 DEFICIENCY)	(X5) COMPLETION DATE
K 911	Continued From page 18 This deficient practice was evidenced by the following: Reference: National Fire Protection Association (NFPA) 101, 9.1.2 Electrical Systems. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless such installations are approved existing installations, which shall be permitted to be continued in service. NFPA 70, 210.8 Ground-Fault Circuit-Interrupter Protection for Personal, Ground-fault circuit-interruption for personal shall be provided as required in 210.8 (A) through (C). The ground-fault circuit-interrupter shall be installed in readily accessible location. (B) Other than Dwelling Units. All 125-volt, single phase, 15- and 20- ampere receptacles installed in locations specified in 210.8 (B) (1) through (8) shall have ground-fault circuit-interrupter protection for personal. (5) Sinks-- where receptacles are installed within 1.8 M (6 feet) of the outside of a sink. On 06/03/2024 (day one of survey) during the survey entrance at approximately 9:20 AM, a request was made to the NJ ex order 26.4b1 NJ ex order to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is three (3) buildings that are connected. The Atrium (#1), the Pavilion (#2) and the Court (#3) buildings.	K 911	affected by these deficient practices. All areas with outlets within 6 feet of a sink were observed GFI rated outlets. Corrections made as necessary. 3. Maintenance staff were re-educated on proper monitoring and maintaining outlets within 6□ of sinks to include GFI rated outlets. 4. Maintenance Director will audit outlets within 6□ of sinks monthly x3 months. Any violations will be corrected immediately. The results of these audits will be reported monthly to the monthly QAPI committee unitl sustained substantial compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315280	A. BUILDING **01, 02, 03** B. WING _____	C **06/05/2024**

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 DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED 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 DEFICIENCY)	(X5) COMPLETION DATE
K 911	Continued From page 19 Starting at approximately 9:41 AM on 06/03/2024 and continued on 06/04/2024, in the presence of the facility [NJ ex o], a tour all three (3) of the building was conducted. During the two (2) day tour of the facility, the surveyor observed and tested nine (9) electrical outlets in wet (with-in 6 feet of a sink) locations with one (1) Duplex electrical outlet that failed to de-energize when tested in the following location, On 06/04 2024 at approximately 12:50 PM, the surveyor observed, measured and recorded in the Atrium Building (#1) Physical Therapy ADL (Activities of Daily Living) kitchen area one (1) Duplex electrical outlet located 5 feet 8 inches to the right of the sink when tested with a Ground Fault Circuit Interrupter (GFCI) tester to de-energize, the Duplex electrical outlet did not de-energize as required by code. The facility [NJ ex o] confirmed the finding at the time of the observation. The [NJ ex order 26.4b1] were informed of the deficiency during the survey exit on 06/04/2024 at approximately 2:20 PM. NJAC 8:39 -31.2 (e) NFPA 99: -6.3.2.1, NFPA 70: -210.8	K 911		

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 03 - THE COURT B. Wing	7/17/2024

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 Reg. # NFPA 101 LSC K0321	Correction Completed 07/15/2024	ID Prefix Reg. # NFPA 101 LSC K0363	Correction Completed 07/15/2024	ID Prefix Reg. # NFPA 101 LSC K0372	Correction Completed 07/15/2024
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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	
6/5/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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 02 - PAVILION B. Wing	7/17/2024

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

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0324	Correction Completed 07/15/2024	ID Prefix Reg. # NFPA 101 LSC K0521	Correction Completed 07/15/2024	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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	
6/5/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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 01 - ATRIUM B. Wing	7/17/2024

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 Reg. # NFPA 101 LSC K0363	Correction Completed 07/15/2024	ID Prefix Reg. # NFPA 101 LSC K0911	Correction Completed 07/15/2024	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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 6/5/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			