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 12/12/2023

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 Survey: 12/12/2023 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 Standard Survey Census: 125 Sample Size: 32 + 2 closed records The facility was not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities. Deficiencies were cited for this survey. C/O # NJ 166324, NJ 165939, NJ 167001, NJ 168042, NJ 166681, NJ 165515, NJ 165165, NJ 165713	F 000		
F 577 SS=D	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of	F 577		1/4/24

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

Electronically Signed | 12/28/2023

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F 577	Continued From page 1 residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation and interviews, it was determined that the facility failed to maintain the most recent State of New Jersey inspection results in a place readily accessible to the residents, families, and the general public. This deficient practice was evidenced by the following: During the Resident Council Meeting on NJ Exec Order 26.4b1 at 10:39 AM, five of five NJ Exec O and NJ Exec Order 26.4b residents said they were not aware of the location of the State Survey results and that the facility had not spoken to them about the results. The residents also indicated they would be interested to read the reports. During a tour of Court 1, Court 2, the Ventilator Unit, and the Pavilion, the surveyor observed that on each unit there was a binder with "State Survey" on the spine of the book, located behind the nurse's station. Each of the binders contained only the last annual survey dated 05/31/2023. There were no posted signs to direct resident's, families, and the general public to the location of the survey results. These binders were not	F 577	Element 1: Court One and Ventilation Unit binders were updated with the last three years of survey results on 12/12/2023, including complaint visits for resident review. The binders were placed in bins with signage above the bins to alert residents and families. Court 2 (Dementia Unit) and The Pavilion (Behavioral Unit) signs were posted for residents and families alerting them where the survey books are for review. Element 2: All residents may be affected by this deficient practice. Element 3: Staff will be educated on alerting the NHA if binders are inaccessible to residents and families related to damage, signs	

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F 577	Continued From page 2 accessible to residents or visitors without asking staff. During an interview with the surveyor on 12/11/2023 at 12:57 PM, the US FOIA (b)(6) said that the survey results are located on the units and down here (motioning towards the Lobby). The US FOIA then said they are on all units at the nurse's station and there are signs on the units saying that. The US FOIA was informed that the surveyor had been on all units and the survey binders were behind the nurse's station and not readily accessible by the residents without having to ask staff. The surveyor also explained that there were no posted signs indicating where the survey results are located and if they are at the nurse's station then the survey results are not readily accessible to the resident without asking.	F 577	falling, or binders that are missing from the bins so replacements can occur. An audit occurred on each floor and all missing information/binders will be corrected immediately. Element 4: An audit will occur monthly by the Nursing Home Administrator or Designee to ensure that signs indicating where survey results are present, and survey binders are available for review. The results of these audits will be reported to the QAPI committee monthly. Results of audits will be reported to the QAPI committee until the committee determines that the issue is resolved or stable. The results will be used for additional training and system changes if necessary.	
F 584 SS=D	NJAC 8:39-9.4(b) 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, 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	F 584		1/4/24

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F 584	Continued From page 3 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: Based observation, interview, and pertinent facility documents it was determined that the facility failed to maintain services necessary to maintain a sanitary, orderly, and comfortable interior specifically by but not limited to leaving stains on the floor and wall, wrappers, and a NJ Exec Order 26.4b1 in a resident bathroom. The deficient practice was observed for 1 of 3 residents (Resident #48) during the Environmental Task. The deficient practice was evidenced by the following:	F 584	Element 1: Resident 48□s room was cleaned. The brown stain on the floor adjacent to the toilet was cleaned and disinfected, the wrapper on the floor, NJ Exec Order 26.4b1 on the top of the toilet tank and the plastic pan on the floor and the plastic cup was discarded on 12/04/2023. Later that same day, clothing on Resident 48□s floor was removed and placed in laundry. NJ Exec Order 26.4b1 was removed from the	

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F 584	Continued From page 4 On 11/28/2023 at 10:45 AM during the initial tour of the facility, the surveyor observed the bathroom in Resident 48's room. At that time, the surveyor observed a brown substance on the floor adjacent to the toilet. On 11/29/2023 at 10:38 AM, the surveyor observed the bathroom in Resident 48's room. At that time, the surveyor observed a brown substance on the floor adjacent to the toilet. On 11/30/2023 at 10:12 AM, the surveyor observed the bathroom in Resident 48's room. At that time the surveyor observed the same brown stain on the floor adjacent to the toilet. In addition, the surveyor also observed a wrapper on the floor, an unpackaged NJ Exec Order 26.4b1 on top of the toilet tank, and a plastic pan on the floor with a plastic cup and discarded paper towel in it. On 12/01/2023 at 09:36 AM, the surveyor observed the bathroom in Resident 48's room. At that time, the surveyor observed clothing on the floor. On 12/04/2023 at 09:35 AM, the surveyor observed the bathroom in Resident 48's room. At that time, the surveyor observed an NJ Exec Order 26.4b1 [redacted] on the floor. The [redacted] appeared to have been [redacted]. The surveyor also observed brown stains on the floor adjacent to the sink. The plastic pan previously observed remained on the floor. On 12/05/2023 at 10:17 AM, the surveyor observed the bathroom in Resident 48's room. At that time, the surveyor observed the same stains	F 584	floor, and the housekeeper cleaned the room, removed brown stains on the floor next to the sink, and the container of body wash on 12/05/2023. On 12/07/2023 multiple housekeeping issues were addressed in Resident 48□s room including brown substance on the toilet seat, dry yellow stain on the floor, toilet paper and paper towels were discarded, trash bag liner replaced, and the room was disinfected. On 12/11/2023 Resident48□s room was placed on special focus cleaning by the housekeeping director. The housekeeping staff were educated in special focus rooms starting on 12/11/2023 and is ongoing. The housekeeper assigned to Resident 48□s room was educated on the cleaning process on 12/11/2023. Resident 48□s care plan was updated to reflect his current ADL needs to reduce the possibility of not being able to provide adequate NJ Exec Order 26.4b1 on 12/11/2023. Nursing staff were educated on 12/11/2023. Element 2: All residents may be affected by this deficient practice. Element 3: Housekeeping staff will be re-educated on the 7-Step process of room cleaning, special focus rooms, and to spot check all room assigned to them prior to deep cleaning so housekeeping issues can be addressed immediately that can cause an	

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F 584	Continued From page 5 on the wall adjacent to the sink. Also on the sink, the surveyor observed a container of body wash that had a thick, discolored crust around the cap. The surveyor also observed that the lid of the toilet tank was not affixed leaving a small opening at the top of the tank. On 12/07/2023 at 12:55 PM, the surveyor observed the bathroom in Resident 48's room. At that time, the surveyor observed a brown substance smeared on the toilet seat. The surveyor also observed a dry, yellow, stain that appeared to have been liquid on the floor. Toilet paper and paper towels were also observed on the floor adjacent to the toilet. Lastly, the surveyor observed that the trash bin did not have a trash bag in it. On 12/01/2023 at 09:58 AM during an interview with the surveyor, the US FOIA (b)(6) replied, "Cleaned daily." when the surveyor asked how often rooms are cleaned. Secondly, the US FOIA (b) replied, "Daily cleaning is disinfect bathrooms, trash ..." when the surveyor asked what does daily cleaning consist of. On 12/05/2023 at 10:32 AM during an interview with the surveyor, Housekeeper #1 said to disinfect, remove trash, spray every piece of furniture, spray floor, dust, and mop when asked what cleaning a resident room entails. On 12/11/2023 at 09:31 AM during an interview with the surveyor, the US FOIA (b) said that resident rooms, including the bathrooms get cleaned everyday. Further, she added that housekeeping does a final walk-through at the end of their shift to see if anything needs to be refreshed. The US FOIA (b) also said that Resident 48's room is a	F 584	unhomelike environment for our residents. Element 4: The Housekeeping director/designee will audit five rooms randomly to ensure a homelike environment for our residents weekly for four weeks then monthly for one month to ensure compliance. Results of audits will be reported to the QAPI committee 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 584	Continued From page 6 "target room" inferring that the room is checked by housekeeping more than once a day. The [redacted] replied, "No" when the surveyor asked if she would consider Resident #48's bathroom a sanitary, orderly, and comfortable interior. A review of the undated facility provided document titled, "7-Step Cleaning Process" revealed under, "4. Clean Bathroom" to, "Start with the door and end with the toilet. Use a bowl mop inside of the toilet and use disinfectant and a damp wiper for the outside of the bowl." N.J.A.C. § 8:39-31.4 (a)	F 584		
F 656 SS=D	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	F 656		1/4/24

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F 656	Continued From page 7 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. (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: 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 1 of 32 sampled residents (Resident #69) sampled. This deficient practice was evidenced by the following: During the initial tour on 11/28/2023 at 11:14 AM, Resident #69 was observed lying in bed with the head of bed elevated and asleep. Resident #69 had a [redacted] to [redacted] According to the Admission Record, Resident #69	F 656	Element 1 The resident's care plan was updated to include all [redacted] needs on [redacted]. Element 2 The facility determined that all residents with could be affected. Element 3 An audit was conducted on 12/13/2023	

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F 656	Continued From page 8 was admitted to the facility with diagnoses including but not limited to: NJ Exec Order 26.4b1 [redacted] and NJ Exec Order 26.4b1 [redacted] A review of the most recent Minimum Data Set (MDS), an assessment tool used to facilitate care, dated NJ Exec Order 26.4b1, revealed Resident #69 had NJ Exec Order 26.4b1. The MDS further indicated under section NJ E that he/she received NJ Exec Order 26.4b1 care and NJ Exec Order 26.4b1 while a resident. A review of the current Physician Order Form revealed the following physician orders with an initiated date of NJ Exec Order 26.4b: NJ Exec Order 26.4b1 [redacted], the NJ Exec Order 26.4b generates the preset NJ Exec Order 26.4b during a prese NJ Exec Order 26.4b1 time at the preset NJ Exec Order 26.4b1 [redacted] NJ Exec Order 26.4b1 q (every) 12 hours and PRN (as needed) change NJ Exec Order 26.4b1 and PRN #9 [brand of NJ Exec Orde NJ Exec Order 26.4b1 with NJ Exec Order 26.4b1 daily as tolerated. NJ Exec Order 26.4b1 to maintain NJ Exec Order 26.4b1 [redacted] NJ Exec Order 26.4 q 12 hours and prn. change NJ Exec Order 26.4b1 [redacted] every 4 days and as needed.	F 656	and ongoing for all residents having tracheostomies. All residents affected care plans were amended to their status by 12/21/23. An education program was conducted with all licensing staff and Unit Managers on ensuring Comprehensive care plans are completed post admission. Facility Educator/ADON/Designee will educate all new clinical nurse hires (agency and staff) on the facility's policy for ensuring that all residents have a comprehensive care plan implemented according to policy. Element 4 The Registered Nurse Assessment Coordinator or Designee will review all new/re admissions in morning meetings to ensure residents have a comprehensive care plan. The Unit Manager will perform random audits weekly of five residents to ensure that the comprehensive care plan has been completed. Results of audits will be reported to the QAPI committee monthly for three months or 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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A further review of the physician orders revealed the following:

A physician order dated [redacted] Rx [redacted] opens during [redacted] and closes at the end of [redacted], re-directing [redacted] through the [redacted] and out through the [redacted], which allows for [redacted] trials up to 2 hours/day as tolerated. continuous [redacted] in place when [redacted] NJ Exec Order 26.4b1

A physician order dated [redacted] to [redacted] trails to during the day as tolerated. change [redacted] continue [redacted] during the day begin [redacted] as tolerated.

A physician order dated [redacted] trails during the day as tolerated. continuous [redacted] in place when [redacted]. [redacted] to maintain [redacted]

A review of the care plan did not include Resident #69's use of a NJ Exec Order 26.4b1, or use of [redacted] or that the resident was actively being NJ Exec Order 26.4b1

During an interview with the surveyor on 12/05/2023 at 10:04 AM, Unit manager/Licensed Practical Nurse (UM/LPN #1) was asked what is the process for new admissions and care plans? UM/LPN #1 replied, "Normally it is the nurse that does the assessment who would initiate the baseline care plan." When asked what would be included on the baseline care plan, UM/LPN #1 said, "Skin, pain, falls, it should be from the time of admission up to the first 72 hours to be

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completed." The surveyor questioned who was responsible to do the care plans. UM/LPN #1 replied, "The nurse who does that admission starts the care plan and then the manager goes through and does a detailed care plan after talking with the resident and family." The surveyor asked when the comprehensive care plans are to be completed. UM/LPN #1 said, "I would say after the first 72 hours the care plan should be complete. We are always adding and adjusting." The surveyor then asked what was expected to be included on the care plan. UM/LPN #1 said, "It would include trach for vent dependent, peg tube, pacemaker, diabetes mellitus, hypertension, air mattress, and any wounds they would have. UM/LPN#1 further revealed that blood thinners, antidepressant medication, antipsychotic medications, antianxiety medications, narcotic medications, and seizures would also be included on their comprehensive care plan.

During an interview on 12/05/2023 at 10:10 AM, the surveyor informed UM/LPN #1 that the surveyor had downloaded Resident #69's care plan on NJ Exec Order 26.4b1 onto the state provided computer. At that time, the surveyor had UM/LPN #1 review what "focus" areas were on the care plan that the surveyor had downloaded. When asked by the surveyor if there was a focus area for the use of the NJ Exec Order 26.4b1 as well as being actively NJ Exec Order 26, UM/LPN #1 said, "It appears the resident has no care plan for NJ Exec Order 26.4b1 or NJ Exec Order 26." When questioned if Resident #69 should have had a care plan for the NJ Exec Order 26.4b1 and NJ Exec Order 26.4b process, UM/LPN #1 confirmed, "Yes, he/she should have had one."

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The surveyor requested UM/LPN #1 to pull up the current care plan now in place for Resident #69 on the facility computer. UM/LPN #1 said that the focus area for Resident #69 had a NJ Exec Order 26.4b1 r/t (related to) NJ Exec Order 26.4b1 as evidenced by NJ Exec Order 26.4b1 Dx (diagnosis): NJ Exec Order 26 and had an initiated date of NJ Exec Order 26.4b The surveyor asked why this would not have shown up on the care plan the surveyor downloaded on their state issued computer. UM/LPN #1 replied, "I don't know." UM/LPN #1 confirmed the dates of the interventions were for the NJ Exec Order 26.4b1 and the interventions were not in place until NJ Exec Order 26.4b1. UM/LPN #1 said she was "Not sure why the initiated date of NJ Exec Order 26.4b and focus area was not there on NJ Exec Order 26.4. The surveyor asked if the focus area had been initiated on NJ Exec Order 26.4b, would the interventions have been put in place at that time. UM/LPN #1 said that "Yes, if the focus area of NJ Exec Order 26.4b1 had been on the care plan the interventions would have been in place before NJ Exec Order 26.4b1. UM/LPN #1 confirmed to the surveyor that since interventions were not put into place until NJ Exec Order 26.4b1 the care plan for Resident #69 was incomplete.

During an interview with the surveyor on 12/11/2023 at 1:00 PM, the US FOIA (b)(6) said care plans should be initiated upon admission, baseline. The US FOIA (b) went on to say she expected the problem/concerns for the residents to be on the care plan with interventions.

During a follow up interview with the surveyor on 12/12/2023 at 10:21 AM, the US FOIA (b) said the comprehensive care plan is to be completed

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F 656	Continued From page 12 within 72 hours of admission. The [US FOIA (b)] confirmed that her expectation would be that for a resident who has [NJ Exec Or], is on [NJ Exec Order] receives NJ Exec Order 26.4b1 and was being actively [NJ Exec Order 26] should have a care plan in place. A review of a facility policy titled Care Plan, with reviewed date of May 2023, revealed under the Policy section: "It is the policy of the [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." The following was revealed under the heading Procedure: 2. They will include initial goals, MD orders, medications, treatments, dietary orders, therapy orders, social services and PASSAR 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of other facility documentation, it was determined that the facility failed to maintain professional standards of clinical practice by not following the physician's order for NJ Exec Order 26.4b1 [redacted] for 1 of 5 residents reviewed for unnecessary medications, (Resident #107).	F 658	Element 1: R-107's NJ Exec Order 26.4b1 were discontinued on [NJ Exec Order 26.4b1]. Element 2:	1/4/24

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F 658	Continued From page 13 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 licensed practical nurse is defined as performing tasks and 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." Reference: New Jersey Statutes Annotated Title 45. Chapter 11. New Jersey Board of Nursing Statutes 45:11-23. Definitions " b. The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or 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 prescribe by a licensed or otherwise legally authorized physician or dentist. Diagnosing in the context of nursing practice means that identification of and discrimination between physical and psychosocial signs and symptoms essential to effective execution and management of the nursing regimen. Such diagnostic privilege is distinct from a medical diagnosis. Treating means selection and performance of those therapeutic measures essential to the effective management and execution of the nursing regimen. Human	F 658	The facility has determined that all residents with medication parameters for blood pressure can be affected. Element 3: An education program was conducted on 12/19/23 and is ongoing with licensed nursing staff on ensuring that residents who has orders for blood pressure parameters document the findings on the Medication Administration Record. Element 4: The Unit Manager or designee will review the MAR of 6 residents with orders for blood pressure parameters weekly x 4 weeks, then monthly x 1 months or until such a time consistent substantial compliance has been determined by the Quality Assurance Committee.	

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response means those signs, symptoms and processes which denote the individual's health need or reaction to an actual or potential health problem.

According to the Admission Record Resident #107 was admitted with the diagnoses including but not limited to; NJ Exec Order 26.4b1.

A review of the Physician Orders, with an original order date of NJ Exec Order 26.4b1, for NJ Exec Order 26.4b1 to be given 1 tablet, by mouth once daily with instructions to hold for a NJ Exec Order 26.4b1

A review of the Consultant Pharmacist's Medication Review, with a review date of NJ Exec Order 26.4b1, the following was documented: "NJ Exec Order 26.4b1 has NJ Exec Order 26.4b1. NJ Exec Order 26.4b1 was not charted from NJ Exec Order 26.4b1. Please review documentation with nursing staff as MD order was not followed."

A review of the Medication Administration Records (MAR) for the months of NJ Exec Order 26.4b1 through NJ Exec Order 26.4b1 revealed there was no documentation of NJ Exec Order 26.4b1s for the NJ Exec Order 26.4b1 as ordered by the physician.

During an interview on with the surveyor on 12/04/2023 at 12:17 PM, the Licensed Practical Nurse (LPN #3) caring for Resident #107, explained the process of administering a medication with NJ Exec Order 26.4b1. "If there are NJ Exec Order 26.4b1 for a medication such as a NJ Exec medication, I will take the residents NJ Exec prior to administering the medication and must always document the NJ Exec on the chart and circle if not

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F 658	Continued From page 15 given." During an interview with the surveyor on 12/11/2023 at 12:44 PM, the US FOIA (b)(6) [redacted], stated the expectations for a [redacted] medication with [redacted] is that prior to administering the medication, the [redacted] should be obtained and reflected on the MAR. If the [redacted] is outside of [redacted], the doctor should be notified. The [redacted] will be reviewed by the Pharmacy Consultant and recommendations will be made based on the [redacted]'s, such as discontinuing or adjusting the dose. A review of a facility policy titled, "Med Administration" with a review date of 05/2023; under Procedure "J" indicated; If required, obtain vital signs before medication administration. Under Procedure "K", "Document necessary medication administration/treatment information on appropriate forms."	F 658		
F 698 SS=D	NJAC 8:39-27.1 (a) Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of the medical record (MR) and review of other facility documentation, it was determined that the facility	F 698	Element 1: The Unit Manager reviewed all the	1/4/24

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F 698	Continued From page 16 failed to ensure communication forms between the facility and a contracted NJ Exec Order 26 facility were consistently completed. This deficient practice was identified for 1 of 1 resident (Resident #60) investigated for NJ Exec Order 26 and was evidenced by the following: According to the Admission Record, Resident #60 was admitted to the facility with the following but not limited to diagnoses: NJ Exec Order 26.4b1 [redacted] According to the NJ Exec Order 26.4b1 Minimum Data Set (MDS), an assessment tool, Resident #60 had NJ Exec Order 26.4b1. Section NJ revealed active diagnosis of NJ Exec Order 26.4b1 [redacted] According to Section NJ, Resident #60 received NJ Exec Order 26 while a resident at the facility. A review of the Physician Order Summary Report, dated NJ Exec Order 26.4b1, revealed the following physician orders for Resident #60: "NJ Exec Order 26.4b1 at [NJ Exec Order 26 center initials] every Tuesday, Thursday, and Saturday at NJ Ex Order 26.4b1 " A review of Resident #60's comprehensive care plan revealed a care plan Focus: "Resident #60 needs NJ Exec Order 26.4b1 r/t (related to) NJ Exec Order 26.4b1 [redacted]. NJ Exec Order 26.4b1 at [facility name] every Tuesday, Thursday, and Saturday. Chair time at NJ Ex Order 26.4b1. Date Initiated: NJ Exec Order 26.4b1 Care planned interventions included: Encourage resident to go for the scheduled NJ Exec Order 26 appointments. Receives NJ Exec Order 26 every Tuesday, Thursday, and Saturday. Date Initiated: NJ Exec Order 26.4b1 ."	F 698	resident□s communication forms and submitted the incomplete forms to the NJ Exec Order 26 Center to be completed on NJ Exec Order 26.4b1. The NJ Exec Order 26.4 Center completed the forms. The [redacted] reviewed the forms and signed acknowledging that she reviewed the forms for any new orders or changes. Element 2: The facility has determined that all residents who receive dialysis can be affected. An audit was conducted on 12/13/23 to determine if any other resident was affected by the deficient practice. No other resident was affected. Element 3: An education program was conducted by the ADON (Assistant Director of Nursing) on 12/19/23 and is ongoing with all licensed nursing staff and Unit Managers reviewing the dialysis communication forms for completion. Element 4: The Unit Manager or Designee will randomly review the dialysis communication form of 5 dialysis residents receiving dialysis for completed dialysis communication form weekly x 4 weeks, then monthly x 1 months. Audited communication forms will be reviewed by the Quality Assurance Committee until consistent substantial compliance is achieved as determined by	

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F 698	Continued From page 17 On 12/01/2023 at10:27 AM, the surveyor reviewed Resident #60's [NJ Exec Order 26.4b1] communication book that is sent with the resident on [NJ Exec Order 26.4b1] treatment days. The communication forms were reviewed for the following dates: [NJ Exec Order 26.4b1], [NJ Exec Order 26.4b1], [NJ Exec Order 26.4b1], [NJ Exec Order 26.4b1], [NJ Exec Order 26.4b1], [NJ Exec Order 26.4b1], [NJ Exec Order 26.4b1], [NJ Exec Order 26.4b1], [NJ Exec Order 26.4b1], [NJ Exec Order 26.4b1], [NJ Exec Order 26.4b1], [NJ Exec Order 26.4b1], and [NJ Exec Order 26.4b1]. The following [NJ Exec Order 26.4b1] communication forms were not completed by the facility nurse: [NJ Exec Order 26.4b1], [NJ Exec Order 26.4b1], [NJ Exec Order 26.4b1], [NJ Exec Order 26.4b1], [NJ Exec Order 26.4b1], [NJ Exec Order 26.4b1], [NJ Exec Order 26.4b1], and [NJ Exec Order 26.4b1]. The following [NJ Exec Order 26.4b1] communication forms were not completed by the [NJ Exec Order 26.4b1] center: [NJ Exec Order 26.4b1], [NJ Exec Order 26.4b1], and [NJ Exec Order 26.4b1]. On 12/5/2023 at 10:50 AM, the surveyor interviewed the Licensed Practical Nurse (LPN#1), assigned to Resident #60's unit. The surveyor asked LPN#1 what the purpose of the [NJ Exec Order 26.4b1] communication book was. LPN #1 stated, "We use the [NJ Exec Order 26.4b1] communication book to document the resident's vital signs and the condition of the resident when they leave for [NJ Exec Order 26.4b1]. The [NJ Exec Order 26.4b1] center will document in the second section on the communication record form. They document the resident's weight, [NJ Exec Order 26.4b1] and any new orders or significant changes." LPN #1 further stated, "If there is a new order for a medication, they will send a prescription also." LPN#1 also said that if the [NJ Exec Order 26.4b1] center does not fill out their section, we would call the center to see what they did at the [NJ Exec Order 26.4b1] center and if there are any new orders or changes." The surveyor lastly asked LPN #1 if the nurse assigned to Resident #60 that shift must fill out the bottom section of the [NJ Exec Order 26.4b1] communication form upon return from [NJ Exec Order 26.4b1].	F 698	the committee.	

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LPN #1 said, "Yes, the assigned nurse will document that they checked their NJ Exec Order 26.4b1 and then sign it (the communication form).

On 12/07/2023 at 09:28 AM the surveyor conducted an interview with LPN #4. The surveyor asked LPN #4 what the purpose of the NJ Exec Order 26 communication book was. The LPN #4 stated, "The purpose of the communication book is to have communication between the NJ Exec Order 26 center and the facility." LPN #4 then proceeded to say, I fill out the NJ Exec Order 26 communication form prior to Resident #60 leaving for NJ Exec Order 26. I also complete his vital signs before leaving. Then NJ Exec Order 26 center will fill out their section of the form while at the NJ Exec Order 26 center. The surveyor asked if NJ Exec Order 26 leaves their section blank what should the assigned nurse do. LPN #4 replied, "I would call the NJ Exec Order 26 center to find out if there are any changes." The surveyor then asked, should the nurse sign the NJ Exec Order 26 communication form upon return to the facility to ensure that the form was reviewed. LPN #4 said, "Yes, the nurse assigned to the resident will fill out the bottom section and sign it."

On 12/11/2023 at 12:45 PM the surveyor interviewed the facility US FOIA (b)(6) and the facility US FOIA (b)(6) The surveyor asked the US FOIA (b)(6) what the purpose of the NJ Exec Order 26 communication book/form was. The US FOIA (b) stated, "The NJ Exec Order 26 form is a communication tool. The NJ Exec Order 26 center can recommend any changes. The nurse assigned to the resident will take vital signs and document it on the form prior to departure. Upon return the nurse that is assigned to the resident will review the form. If NJ Exec Order 26 recommends anything the nurse will notify the physician." The surveyor then asked the

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[redacted] what should be done if the [redacted] communication form is received blank from the [redacted] treatment center. The [redacted] stated, "They should contact [redacted] to see if there are any new communications or recommendations." The surveyor asked the facility [redacted] if the assigned nurse should complete the [redacted] communication record form upon return from [redacted]. The [redacted] said, "Yes, upon return the nurse should review the communication form and sign off at the bottom. Lastly the surveyor asked, should the nurse contact the [redacted] center if that section was left blank? The facility [redacted] stated, "Theoretically yes, to see if there are any changes or new orders. If the nurse communicates with the [redacted] center verbally over the phone the nurse should have documented, it in a progress note with any new information."

A review of a facility policy and procedure with Subject: Dialysis Management (Hemodialysis), last date reviewed: 5/2023. The following was revealed under the Procedure if Dialysis is provided at off-site Dialysis Center:

5. Assure facility completed Dialysis communication form accompanies resident to dialysis on treatment days, to communicate resident information and coordinate care between Dialysis Center and facility.

6. Dialysis center personnel to complete Dialysis communication form and return to facility.

7. Upon return from Dialysis Center, review information provided on Dialysis communication form. Communicate and address as appropriate. Complete post-dialysis information and place in resident's medical record.

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F 812 SS=F	N.J.A.C. 8:39-27.1 (a) 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 facility documentation, 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 11/28/2023 from 9:28 to 10:01 AM, the surveyors, accompanied by the US FOIA (b)(6) [redacted] observed the following in the	F 812	Element 1: The open bag of raisins and 2 containers of ground nutmeg with an expired date were discarded on 11/28/2023. Normans 50 Lite yogurt was discarded on 12/05/2023. A yellow plastic bag containing resident food, and a blue bag containing NJ Ex Order 26.4b [redacted] and an apple were discarded on 12/05/2023. On 12/08/2023 the US FOIA (b)(6) [redacted] operating	1/4/24

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F 812	Continued From page 21 kitchen: 1. In the dry storage room on a middle shelf a previously opened bag of raisins wrapped in plastic wrap had a use by date of "11/24/23." The US FOIA (removed the expired raisins to the trash. 2. On a middle shelf (2) containers of unopened Ground Nutmeg had a received date of "6/29/22." The US FOIA (stated that herbs and spices are good for one year. The US FOIA (removed the outdated containers of nutmeg to the trash. On 12/05/2023 from 10:00 to 10:12 AM, the surveyor, accompanied by the Licensed Practical Nurse (LPN #2) observed the following on the Court 1 Pantry: 1. In the freezer, a "NJ Ex Order 26.4b1" yogurt was frozen. The product had a facility provided label dated "11/29/23." The yogurt had a manufacturer's BB (best by) date of "Oct 03, 23." 2. In a bottom drawer of the refrigerator a yellow plastic bag contained unidentified resident food. The bag was labeled with the resident name, but no dates were observed on the food or the bag to indicate when the food was placed in the refrigerator. In addition, on the inside of the refrigerator door a blue bag contained what appeared to be NJ Exec Order 26, take-out food and an apple. The bag had no name or date to identify who it belonged to and when it was placed in the refrigerator. The surveyor asked LPN #2 who was responsible for the monitoring of foods in the Court 1 pantry. LPN #2 replied, "Nursing is responsible for monitoring the refrigerator. 11-7 shift does the temperatures and throughout the day the nurses monitor the food aspect." The	F 812	the dish machine was educated, and a competency performed on dietary staff was completed on 12/08/2023. The facility used paper products until a service technician repaired the dish machine on 12/08/2023 about 3pm. A bulk storage container containing thickener was replaced on 12/08/2023. The ¿ pan of collard greens that was mislabeled with an incorrect date was discarded on 12/08/2023. The sanitized plates were covered with an appropriate cover on 12/08/2023. Dietary staff were educated on the concerns addressed during the survey period beginning on 12/08/2023 and is ongoing. Element 2: All residents may be affected by this deficient practice. Element 3: An audit was conducted on 12/12/2023 regarding dry storage, dry plate/utensil storage, food stored in refrigerators, bulk dry storage containers and dish machine sanitization to ensure that the facility is compliant with F812. All items found during the audit will be corrected immediately. Dietary staff started education on 12/08/2023 on the facility policies and procedures on dry storage, disposing of expired dry items, storage of food items in	

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F 812	Continued From page 22 surveyor then asked LPN #2 if resident food needed to be labeled with a name and date when placed in the refrigerator/freezer. LPN #2 responded, "I agree the food should be dated when put in the refrigerator." LPN #2 removed the food to the trash in the presence of the surveyor. On 12/08/2023 from 10:20 to 11:01 AM, the surveyors, accompanied by the [redacted], observed the following in the kitchen: 1. On 12/08/2023 at 10:22 AM upon entering the kitchen the surveyors observed the dish machine in operation and kitchen staff actively washing dishware from the breakfast meal. The surveyor asked the [redacted] to provide the surveyor with the dish machine temperature/sanitizer log. The [redacted] provided the surveyors a clipboard with the "Dec 2023" Dish Machine Ware washing - Low Temperature form attached. Review of the form revealed that the form was completed for breakfast, lunch, and dinner from 12/1-12/7/2023 at dinner. At 10:26 AM, the surveyors observed kitchen staff actively washing dishes after the breakfast meal. Review of the log revealed that no wash or rinse temperature was recorded on 12/8/2023 at breakfast. The form also indicated that the chlorine sanitizer level was not recorded in parts per million (ppm) for the breakfast meal on 12/8/2023. The surveyor asked the [redacted] if it was policy to ensure and record the wash and rinse temperatures and sanitizer (chlorine) level prior to initiating dish washing. The [redacted] agreed that the dish machine temperature and chlorine level should be recorded prior to initiating dishwashing to ensure that the dish machine is functioning properly. At approximately 10:28 AM while the dish machine was in operation the surveyor observed a wash temperature of 142	F 812	refrigerators, and dish machine sanitization and infection control. Element 4: The Dietary Director/designee will audit dry storage areas for expired items, refrigerators in pantry for outdated, expired or unlabeled food items, dry storage bins are in good condition, free or cracks or cracked lids, all sanitized dishes are covered per facility policy, walk in fridge has no expired or undated items in storage, dish machines PPM is checked and recorded prior to running the dish machine weekly for 4 weeks then monthly for one month to ensure compliance with F812. Results of audits will be reported to the QAPI committee until the committee determines that the issue is resolved or stable. The results will be used for additional training and system changes if necessary.	

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 12/12/2023

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 812	Continued From page 23	F 812		

Fahrenheit (F) and a rinse temperature of 140 F. The [redacted] then waited for a plastic rack used to hold dirty dishes to exit the dish machine. The plastic rack held a small plastic bucket that collected the dish machine water to test for chlorine sanitizer levels. Once the rack exited the machine with the plastic bucket half filled with dish machine water, the [redacted] obtained a paper chlorine test strip from its plastic dispenser. The [redacted] inserted the chlorine test strip into the bucket of dish machine water and quickly removed it, as per manufacturer instructions. Observation of the test strip revealed that the test strip remained white in color and did not indicate that any chlorine was present in the dish machine water used to clean resident used dishware. The surveyor and the [redacted] agreed to place the rack and emptied bucket back through the dish machine again to ensure the accuracy of the chlorine sanitizer level. Upon exiting the dish machine, the [redacted] obtained another chlorine test strip from the dispenser and inserted it into the bucket that contained dish machine wash/rinse water. The [redacted] quickly removed the test strip after submerging it in the dish machine water, as per manufacturer instruction. The surveyor and [redacted] compared the test strip to the color chart on the test strip dispenser. The test strip was observed to have no color change and remained white in color after inserting into the bucket of dish machine water. The minimum standard/concentration of chlorine is 50 ppm to ensure adequate sanitization of dishware. The test strip twice indicated that the dish machine was in operation and had less than 10 ppm of chlorine, per the manufacturer color chart located on the test strip dispenser. The surveyor then conducted an interview with the US FOIA (b)(6) assigned to run the dish machine for the

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	315280	A. BUILDING _____ B. WING _____	C 12/12/2023

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 812	Continued From page 24	F 812		

breakfast meal. The surveyor asked the US FOIA if he observed the dish machine wash and rinse temperature and if he checked the chlorine level prior to cleaning the breakfast dishware. The US FOIA stated, "they told me that I check the temperatures and chlorine after dishwashing was completed. I did not check before dishwashing this morning." At this point he US FOIA (instructed staff that they would utilize paper products for the lunch meal due to inadequate sanitization of the breakfast dishware. The US FOIA (b) stated they were going to call their service company to immediately come and service the dish machine. The US FOIA (b) agreed the US FOIA who was assigned as the dishwasher did not check the temperature or sanitizer level prior to initiating dish washing this AM. On 12/11/2023, the facility US FOIA (b)(6) provided the surveyor with a copy of the dish machine service invoice, dated 12/08/2023 at 12:00 PM. The invoice indicated that the dish machine had a "clogged detergent bowl. In addition, the "sanitizer squeeze tube and injector fitting were worn."

2. In the dry storage room, a (4) wheeled cart was in the center of the dry storage room. The cart contained a bulk container and contained "Thickener", used to thicken foods and liquids for resident meals. The lid to the container was broken and the thickener was exposed."

3. A 4 wheeled, multi-tiered rack contained a full pan covered with foil wrap in the walk-in refrigerator. The 1/2 pan was labeled "collard greens" and were dated "10/4-10/6." They were supposed to be dated 12/4-12/6, according to the US FOIA (b)(6) stated, "They're going in the trash. There out of date."

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F 812	Continued From page 25	F 812		

3. In the tray line area of the kitchen, (2) plate warming carts contained (2) columns of cleaned and sanitized plates used for resident meals. The plates were not in the inverted position and did not have a cover. The plates were exposed to contamination.

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

3. Food or beverage items may be stored in the resident's room or in facility pantries, refrigerators or freezers or resident's personal room refrigerators, if applicable.

b. All cooked or prepared food brought in for the resident and stored in the unit's pantry refrigerator or personal room refrigerator will be dated when accepted for storage and discards after 72 hours. Unlabeled/undated food found will be discarded immediately.

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

The surveyor reviewed the facility policy titled Pot Washing (mechanical) Policy, undated. The following was revealed under the heading Procedure:

9. Pot washing staff will monitor and record pot machine temperatures to assure proper sanitation.

11. Low temp (Wash 120 degrees F, Rinse 120 degrees F). Must use a chlorine test strip after

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F 812	Continued From page 26	F 812		

each use using 50 parts per million solution.

12. FSD or designee will spot check and log temperature and PPM reading prior to each usage.

The surveyor reviewed the facility policy titled CCS Food Storage Criteria, undated. The following was revealed under Criteria for Refrigerator Storage:

1.5 Ready-to-eat refrigerated foods are labeled according to FDA or state standards (e.g., the date or day by which the food should be consumed, sold, or discarded).

1.6 Refrigerated ready-to-eat food that is not labeled is discarded.

1.8 Staff receives training on the proper refrigerator storage time and temperature.

1.14 Personnel look for and follow "Use by" dates. (For example: "Use by" dates mean that a product cannot be used after that date, even if it appears and smells good. Products can be safely frozen before the "use by" date. Follow guidelines on the Freezer Storage Chart.)

The following was revealed under the heading Criteria for Dry Food Storage:

3.8 Staff receives training on the proper dry food storage time and temperature.

3.9 Storage area is kept clean, secure, and is inspected regularly.

3.12 Personnel look for and follow "best before"

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F 812	Continued From page 27	F 812		

dates. They also honor "store in a cool dry place" or "keep in the refrigerator once opened."

The surveyor reviewed the facility policy titled Dishwashing Procedure, undated. The following was revealed:

12. Either 2 people are in the dish room, one on the dirty side, one on the clean side or if one person does both they must wash and sanitize their hands between dirty and clean areas. The sanitizer may be a sanitizing agent dispensed from the wall area or a bucket of bleach water, which is marked "bleach water" and is 50ppm.

The surveyor reviewed the facility policy titled Dating and Labeling Policy, (rev. 1-24-2017). The following was revealed under the heading POLICY:

Kitchen will assure safety by maintaining proper dates and labels to all goods and ready to eat food products.

In addition, the following was revealed under PROCEDURE:

2. Label products in storage with date the package was opened.

4. Ready to eat foods must be dated with a 72 hour use by date and discarded when expired.

10. Discard all foods that expire immediately.

N.J.A.C. 18:39-17.2(g)

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 12/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 000	Initial Comments C/O # NJ 166324, NJ 165939, NJ 167001, NJ 168042, NJ 166681, NJ 165515, NJ 165165, NJ 165713 The facility was not in compliance with the standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiecncy and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisisons of the New Jersey Admiistrative Code, Title 8, Chapter 43E, enforcement of Licensure.	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: C/O # NJ 166324, NJ 165939, NJ 167001, NJ 168042, NJ 166681, NJ 165515, NJ 165165, NJ 165713 Based on interviews and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios as mandated by the state of New Jersey. This was evident for 1.) 2 of 14 day shifts for the period of 08/13/2023 to 08/26/2023 2.) 1 of 7 day shifts for the period of 10/01/2023 to 10/07/2023 and 3.) 2 of 14 day	S 560	Step 1 US FOIA (b)(6) was immediately in-serviced on the requirements. Step 2 All residents have the potential to be affected by the deficient practice of not meeting the New Jersey staffing requirement ratios.	1/4/24

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

Electronically Signed | 12/28/23

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 12/12/2023

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S 560	Continued From page 1 shifts for the period of 11/12/2023 to 11/25/2023. Findings include: Reference: New Jersey Department of Health (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. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (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. 1. For the 2 weeks of Complaint staffing from 08/13/2023 to 08/26/2023, the facility was deficient in CNA staffing for residents on 2 of 14 day shifts as follows: -08/13/22 had 13 CNAs for 126 residents on the day shift, required at least 16 CNAs. -08/19/23 had 13 CNAs for 124 residents on the day shift, required at least 15 CNAs. 2. For the week of Complaint staffing from 10/01/2023 to 10/07/2023, the facility was deficient in CNA staffing for residents on 1 of 7	S 560	Step 3 The following measures are in place to prevent the deficient practice from reoccurring. Advertisements and Job postings for C.N.A.s have been posted on recruitment platforms. Bonuses are awarded to staff to encourage shift coverage. Staffing ratios are discussed during the morning operations meeting to evaluate compliance. A weekly staffing meeting is conducted to ensure all recruitment platforms available are being utilized, that all candidates are being interviewed in a timely manner and weekly orientation classes occur. The facility has multiple agency contracts and a preferred agency contract that has provided the facility with blocked CNA and LPN/RN staffing. The facility has increased licensed and certified nursing assistant salaries to compete with area facilities. A corporate recruiter has been assigned to the facility to provide guidance and recruitment expertise to ensure compliance with S560. Step 4 The Administrator/designee will review the staffing schedule weekly to monitor the staffing on the 7-3pm shift for 4 weeks. The Administrator/designee will attend the weekly staffing meeting to ensure all efforts are being made to recruit qualified staff for the facility. The results of these audits will be reported	

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 12/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 560	Continued From page 2 day shifts as follows: -10/01/23 had 9 CNAs for 132 residents on the day shift, required at least 16 CNAs. 3. For the 2 weeks of staffing prior to survey from 11/12/2023 to 11/25/2023, the facility was deficient in CNA staffing for residents on 2 of 14 day shifts as follows: -11/24/23 had 14 CNAs for 126 residents on the day shift, required at least 16 CNAs. -11/25/23 had 12 CNAs for 126 residents on the day shift, required at least 16 CNAs. On 12/08/2023 at 09:35 AM the surveyor conducted an interview with the facility [redacted]. The surveyor asked the [redacted] if she was familiar with the minimum staffing requirements for nursing homes. The [redacted] responded, "Yes I am familiar with the minimum staffing mandate. The requirements are 7-3 is 1 CNA to 8 residents, 3-11 is 1 CNA to 10 residents, and 11-7 is 1 CNA to 14 residents." The surveyor then asked the facility [redacted] if the facility consistently meets the minimum mandated staffing requirements. The [redacted] told the surveyor, "We meet the requirements on most days. I do have trouble sometimes on the weekends and on Mondays. Mostly due to people calling out. It's mostly call outs."	S 560	to the QAPI committee monthly. Results of audits will be reported to the QAPI committee to ensure compliance. The results will be used for additional training and system changes if necessary.	

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	1/16/2024 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 F0577	Correction	ID Prefix F0584	Correction	ID Prefix F0656	Correction
Reg. # 483.10(g)(10)(11)	Completed	Reg. # 483.10(i)(1)-(7)	Completed	Reg. # 483.21(b)(1)(3)	Completed
LSC	01/04/2024	LSC	01/04/2024	LSC	01/04/2024
ID Prefix F0658	Correction	ID Prefix F0698	Correction	ID Prefix F0812	Correction
Reg. # 483.21(b)(3)(i)	Completed	Reg. # 483.25(l)	Completed	Reg. # 483.60(i)(1)(2)	Completed
LSC	01/04/2024	LSC	01/04/2024	LSC	01/04/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
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	
12/12/2023	☐ 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 B. Wing	1/16/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0584 Reg. # 483.10(i)(1)-(7) LSC	Correction Completed 01/04/2024	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
12/12/2023

☐ 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 (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
060407	A. Building B. Wing	1/16/2024

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 01/04/2024	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 12/12/2023	☐ 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** B. WING _____	**12/12/2023**

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 8/24, 25 and 29/2022, 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 Silver Healthcare Center is a two-story building that was built in the 1980's. It is composed of Type V protected. The facility is divided into 19 smoke zones.	K 000		
K 281 SS=D	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by: Based on observations and review of facility provided documentation on 11/28/2023, 11/29/2023 and 11/30/2023, it was determined that the facility failed to ensure continuous illumination for 2 of 21 designated exit discharges was provided and arranged so that the failure of any single lighting unit did not result in an illumination level of lass than 0.2 ft-candle in any designated area in accordance with NFPA 101 Life Safety Code (2021 edition) Sections 7.8.1.1,	K 281	Element 1: US FOIA (b)(6) , LLC was notified on 12/12/2023 to provide an estimate and install a lighting fixture outside of Court One, near the Residents Dining Room outside of the exit discharge door and an external lighting fixture on the Atrium building outside an exit discharge door - work completed. work order submitted to	1/8/24

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

Electronically Signed | 12/27/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315280	A. BUILDING **01** B. WING _____	**12/12/2023**

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K 281	Continued From page 1 7.8.1.2 and 7.8.1.4 The evidence includes the following, On 11/28/2023 (day one of survey), during the survey entrance at approximately 9:13 AM, a request was made to the US FOIA (b)(6) and US FOIA (b)(6)) to provide a copy of the facility lay-out which identifies the various rooms and common areas in the facility. A review of the facility provided lay-out identified there are three (3) buildings that are connected together, the Atrium, the Pavilion and the Court buildings. The Atrium building has eleven (11) designated (illuminated exit signs above doors) exit discharge doors, the Pavilion building has six (6) designated exit discharge doors and the Court building has four (4) designated exit discharge doors in the facility for Residents, Visitors and staff to use during an evacuation in the facility. Starting at approximately 9:54 AM on 11/28/2023 and continued on 11/29/2023, and 11/30/2023 in the presence of the facility US FOIA, a tour of the building was conducted. During the three (3) day building tour the of the facility the surveyor observed two (2) designated exit discharge doors that failed to provide proper illumination in the following areas, On 11/29/2023, 1) At approximately 11:59 AM, the surveyor observed on Court One, the Residents dining room outside of a designated exit discharge door had no external lights. A review of an emergency evacuation diagram posted in the corridor identify this exit discharge	K 281	DOH via email. Element 2: All residents have the potential to be affected by the deficient practice. Element 3: Maintenance staff educated on K291 regarding external lighting and the importance of maintaining proper lighting/illumination at means of Egress. Maintenance will immediately perform an audit of all means of Egress for appropriate illumination, and then will conduct a weekly audit x2 months to ensure the deficit practice does not reoccur and that all appropriate lighting/illumination at means of egress remains in place. Element 4: A random external exit illumination audit 4 times will be conducted monthly for two months to ensure compliance with K281. Results of audits will be reported to the monthly QAPI committee 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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K 281	Continued From page 2 door as the primary and or secondary exit discharge door. On 11/30/2023, 2) At approximately 10:04 AM, the surveyor observed on the Atrium building outside a designated exit discharge door (near the Maintenance office) had no external lights. A review of an emergency evacuation diagram posted in the corridor identify this exit discharge door as the primary and or secondary exit discharge door. The US FOIA confirmed the findings at the time of observations. The US FOIA (b)(6) was informed of the deficiency during the survey exit on 11/30/2023 at approximately 11:45 AM. N.J.A.C. 8:39 -31.2 (e) NFPA 101 2012 -19.2.8	K 281		
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____	K 353		1/8/24

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K 353	Continued From page 3 c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on interview and record review on 11/28/2023 and 11/29/2023, in the presence of facility management, it was determined that the facility failed to comply with the inspection and testing requirements NFPA 25 as evidenced by the following: On 11/28/2023, during the survey entrance at approximately 9:13 AM, a request was made to the US FOIA (b)(6) and US FOIA (b)(6)) to provide all mandatory inspections that had been conducted from 06/01/2022 through 11/27/2023 for review. Later at approximately 11:52 AM, during the documentation review of the mandatory inspections of the facility's quarterly (every 3 months) fire sprinkler system inspections for the previous 17 months, identified the system had the following quarterly sprinkler system inspection reports, - 6/27/2022, 9/13/2022 and 12/02/2022. - 3/09/2023 and 6/29/2023. At approximately 1:21 PM on 11/28/2023, the surveyor asked the facility US FOIA if there were any other quarterly (every 3 months) sprinkler system inspections. The US FOIA could not provide any additional quarterly sprinkler inspections.	K 353	Element 1: The quarter 3 inspection was not completed and could not be corrected. Quarter 4 inspection was completed on 12/14/2023 and 12/15/2023. Element 2: All residents have the potential to be affected by the deficient practice. Element 3: The Maintenance Director contacted the vendor for a routine quarterly inspection schedule on 12/12/2023. The Executive Director will educate the maintenance department regarding compliance with K-353 and quarterly sprinkler system inspections (completed on 12/26/2023). Element 4: The maintenance director/designee will audit quarterly sprinkler system inspections monthly for two months to ensure compliance. Results of audits will be reported to the QAPI committee monthly for three months or until the committee determines that the issue is	

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K 353	Continued From page 4 The facility did not conduct a quarterly fire sprinkler system inspection between 06/29/2023 and 11/28/20232. The facility failed to conducted quarterly (every three months) sprinkler inspections for the year 2023 as required per NFPA 25. The US FOIA (b)(6) was informed of the deficiency during the survey exit on 11/30/2023 at approximately 11:45 AM. NJAC 8:39-31.2(e) NFPA 25	K 353	resolved or stable. The results will be used for additional training and system changes if necessary.	
K 355 SS=E	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and review of facility documentation on 11/28/2023, 11/29/2023 and 11/30/2023 in the presence of facility management, it was determined that the facility failed to: Perform a monthly visual examination inspection for 4 of 37 portable fire extinguishers observed and inspected as per, Edition, Section 19.3.5.12, 9.7.4.1 and National Fire Protection Association (NFPA) 10, 2010 Edition, Sections 6.1, 6.1.3.8.1 and 6.1.3.8.3 and N.J.A.C. 5:70. Reference #1 NFPA 10 Edition 2010 Standard	K 355	Element 1: The maintenance director inspected the ABC-type fire extinguisher located inside the commercial laundry room, the Court 2 Residents Dining Room, Court 2 storage room in the old dialysis center, and in the Court 1 office. The maintenance director placed a tag verifying the inspection of the ABC-type fire extinguisher. Element 2:	1/8/24

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K 355	Continued From page 5 for portable fire extinguishers reads, - 4- 3 Inspection Maintenance. - 4- 3.1 Frequency. Fire extinguishers shall be inspected when initially placed in service and there after at approximately 30-day intervals. Fire extinguishers shall be inspected at more frequent intervals when circumstances require. - 4- 3.3 Corrective Action. When an inspection of any fire extinguisher reveals a deficiency in any conditions listed in 4- 3.2 (a), (b), (h), and (i), immediate corrective action shall be taken. - 4-3.4 At least monthly, the date the inspection was performed and the initials of the person performing the inspection shall be recorded at least monthly and that records shall be kept on a tag or label attached to the fire extinguishers. - 7.3.1.1.1 Fire extinguishers shall be subjected to maintenance at intervals of not more than 1 years at the time of hydrostatic test, or when specifically indicated by an inspection or electronic notification. The findings include the following, On 11/28/2023 (day one of survey) during the survey entrance at approximately 9:13 AM, a request was made to the US FOIA (b)(6) and 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, the Pavilion and the Court buildings. The Atrium building has 43 Resident sleeping rooms, the Pavilion building has 23 Resident sleeping rooms and the Court building has 82 Resident sleeping rooms.	K 355	All residents have the potential to be affected by the deficient practice. Element 3: The maintenance department was educated on 12/26/2023 on K355 and portable fire extinguisher inspections. The maintenance department will conduct monthly inspections and record the results of the inspection on the portable fire extinguisher and TELs to ensure compliance. Element 4: A random monthly audit will be conducted by the Executive Director/designee on 5 fire extinguishers monthly to ensure compliance for two months. Results of audits will be reported to the QAPI committee monthly for three months or 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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K 355	Continued From page 6 Starting on 11/28/2023 at approximately 9:00 AM and continued on 11/29/2023 and 11/30/2023, in the presence of the facility's [redacted] a tour of the facility was conducted. During the three (3) day building tour the surveyor observed and inspected thirty-seven (37) portable fire extinguishers that were last annually inspected July 2023 in various locations. The surveyor observed 4 fire extinguishers with the following issues that were identified: On 11/29/2023: 1) At approximately 9:32 AM, inside the Commercial laundry room one (1) ABC-type fire extinguisher was last annually inspected July with no evidence of a monthly visual examination performed and documented on the tag attached to the fire extinguisher for August, September and October 2023. 2) At approximately 10:05 AM, inside the Court 2 Residents Dining/ Activity room one (1) ABC-Type fire extinguisher last annually inspected July 2023 with no evidence of a monthly visual examination performed and documented on the tag attached to the fire extinguisher for August, September and October 2023. 3) At approximately 10:30 AM, inside the Court 2 (second floor) storage room (old Dialysis area) one (1) ABC-Type fire extinguisher was last annually inspected December 2021. 4) At approximately 11:29 AM, one (1) ABC-Type fire extinguisher inside Court 1 office was last annually inspected July 2023 no evidence of a monthly visual examination	K 355		

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K 355	Continued From page 7 performed and documented on the tag attached to the fire extinguisher for August, September and October 2023. The US FOIA confirmed the findings at the time of documentation review. The US FOIA (b)(6) was informed of the deficiency during the survey exit on 11/30/2023 at approximately 11:45 AM.	K 355		
K 363 SS=E	NFPA 10 NJAC 8:39 -31.1 (c), 31.2 (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. 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	K 363		1/8/24

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K 363	Continued From page 8 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 5/31/2023 survey. Based on observation on 11/28/2023, 11/29/2023 and 11/30/2023, in the presence of facility management it was determined that the facility failed to ensure that 6 of 36 corridor doors inspected and tested, 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 following: On 11/28/2023 (day one of survey) during the survey entrance at approximately 9:13 AM, a request was made to the US FOIA (b)(6) and 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	K 363	Element 1: The doorknob was replaced in the medical supply room near resident room 329 on 12/22/2023. There is no longer a penetration noted. The maintenance director will evaluate all doors on the Pavilion unit and correct doors found to be out of compliance or contract out for repair/replacement of those doors found to be affected. Additionally, the maintenance director/designee will evaluate the door in the Pavilion central shower room to diagnose the inch gap along the top edge of the door if cannot be repaired, will be contracted to professionally repair or replace door, the 1-5/8-inch gap on the bottom of the door in Court 1 building, the inch gap along the top of the door in the Atrium housekeeping room, the Atrium	

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K 363	Continued From page 9 together, the Atrium, the Pavilion and the Court buildings. The Atrium building has 43 Resident sleeping rooms, the Pavilion building has 23 Resident sleeping rooms and the Court building has 82 Resident sleeping rooms. Starting on 11/28/2023 at approximately 9:00 AM and continued on 11/29/2023 and 11/30/2023, in the presence of the facility's [redacted] a tour of the facility was conducted. During the three (3) day tour of the facility the surveyor performed closure tests of the thirty-six (36) doors in the corridors with the following results, On 11/28/2023: 1) At approximately 9:06 AM, in the Atrium building the surveyor observed that the Medical supply room to the right of Resident room #329, had no evidence of a door knob. This left an approximately one (1) 1 inch hole and two (2) 1/4 inch holes through the 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 10:40 AM, in the Pavilion buildings Central Shower room, during a closure test of the corridor door there was a 1/4 gap along the top edge. This would allow fire, smoke and poisonous gases to pass into the exit access corridor in the event of a fire. This is a repeat deficiency of the 5/31/2023 survey. On 11/29/2023: 3) At approximately 11:22 AM, in the Court 1	K 363	building door of the Residents Spa room inch gap along the top of the door. If the maintenance director cannot repair the doors, our vendor will be contacted to provide an estimate to repair or replace the doors. The door in the Atrium building near unoccupied resident room 333 that would not close was repaired by the maintenance department and now latches correctly. Element 2: All residents have the potential to be affected by the deficient practice. Element 3: The maintenance director and department were educated on 12/26/2023 on K 363 to ensure compliance. The Maintenance Director will make monthly rounds to ensure doors do not have gaps or penetrations and document in the TELS system. Element 4: The maintenance director/designee will audit 10 doors weekly for four weeks then 10 doors monthly for two month to ensure compliance. Results of audits will be reported to the QAPI committee monthly or 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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K 363	Continued From page 10 building, during a closure test of Resident room #131, the surveyor observed and measured an approximately 1-5/8 of an inch gap along the doors bottom edge. This would allow fire, smoke and poisonous gases to pass into the exit access corridor in the event of a fire. On 11/30/2023: 4) At approximately 10:10 AM, in the Atrium building, during a closure test of Resident room #333, the surveyor observed the door did not remain closed into its frame as required. The door knobs keeper was missing. This would allow fire, smoke and poisonous gases to pass into the exit access corridor in the event of a fire. 5) At approximately 10:33 AM, in the Atrium building, during a closure test of the Housekeeping rooms corridor door (Near the unit managers office), the surveyor observed an approximately 1/4 of an inch gap along the top of the door and an approximately 1/2 gap along the door edge where it meets the doors frame. This would allow fire, smoke and poisonous gases to pass into the exit access corridor in the event of a fire. 6) At approximately 10:40 AM, in the Atrium building, during a closure test of the Residents Spa room door, the surveyor observed an approximately 1/4 inch gap along the top of the door. 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 times of observations. The US FOIA (b)(6) was informed of the	K 363		

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K 363	Continued From page 11 deficiency during the survey exit on 11/30/2023 at approximately 11:45 AM. 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 521 SS=D	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: Based on observations on 11/28/2022, 11/29/2023 and 11/30/2023 in the presence of facility management, it was determined that the facility failed to : 1) Ensure that the facility's ventilation systems were being properly maintained for 2 of 12 Resident bathroom exhaust systems, as per the National Fire Protection Association (NFPA) 90A. This deficient practice was evidenced by the following: On 11/28/2023 (day one of survey) during the survey entrance at approximately 9:13 AM, a request was made to the US FOIA (b)(6)) and US FOIA (b)(6)) to provide a copy of the facility lay-out which identifies the various	K 521	Element 1: Contractor contacted to provide assessment and estimate for repair/replacement of the air ventilation system that effects rooms 410 and 415 located in the Pavilion Unit on November 19th, 2023. On 12/26/2023 the air ventilation systems in room 410 and 415 were repaired by vendor and is currently in full operating order. Element 2: All residents have the potential to be affected by the deficient practice.	1/8/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315280	A. BUILDING **01** B. WING _____	**12/12/2023**

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 12 rooms and smoke compartments in the facility. The surveyor also asked how many Resident sleeping rooms are in the facility. The [redacted] 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, the Pavilion and the Court buildings. Starting at approximately 9:54 AM on 11/28/2023 and continued on 11/29/2023, 11/30/2023 in the presence of the facility [redacted] a tour of the building was conducted. During the three (3) day tour of the facility, the surveyor inspected twelve (12) 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 2 of 12 resident bathrooms in the following locations: On 11/28/2023: 1. At approximately 10:10 AM, in the Pavilion building Resident room #410 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 10:12 AM, in the Pavilion building Resident room #415 bathroom, when tested the exhaust system did not function properly. This bathroom had no window with an	K 521	Element 3: The maintenance director will add quarterly routine maintenance checks on bathroom ventilation and notify NHA if any concerns are noted with the functioning of fans that provide ventilation of resident bathrooms. Maintenance staff was educated on K 521 regarding bathroom ventilation on 12/26/2023. Element 4: The maintenance director/designee will audit 10 rooms weekly to ensure proper ventilation (by placing a piece of single ply tissue paper across the grills to confirm ventilation is present) for four weeks then 10 rooms monthly to ensure compliance. Results of audits will be reported to the QAPI committee monthly for three months or 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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K 521	Continued From page 13 area that would open. This bathroom would rely on mechanical ventilation. The [redacted] confirmed the findings at the time of observations. The US FOIA (b)(6) was informed of the deficiency during the survey exit on 11/30/2023 at approximately 11:45 AM. 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 11/28/2023, 11/29/2023 and 11/30/2023, in the presence of facility management, it was determined that the facility failed to ensure that 1 of 12 electrical outlets located next to a water source (with-in 6 feet) was equipped with Ground-Fault Circuit Interrupter (GFCI) protection. This deficient practice was evidenced by the following: Reference: National Fire Protection Association (NFPA) 101, 9.1.2 Electrical Systems. Electrical wiring and	K 911	Element 1: Room 421□s GFCI electrical outlet was replaced by the maintenance department on 11/29/2023 and was tested and de-energized as required by code. Element 2: All residents have the potential to be affected by the deficient practice. An audit was initiated on 11/29/2023 and is ongoing to inspect every room to ensure	1/8/24

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K 911	Continued From page 14 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 11/28/2023 (day one of survey) during the survey entrance at approximately 9:13 AM, a request was made to the US FOIA (b)(6) and 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 the facility is three (3) buildings that are connected. The Atrium, the Pavilion and the Court buildings. Starting at approximately 9:54 AM on 11/28/2023 and continued on 11/29/2023, 11/30/2023 in the presence of the facility US FOIA a tour of the building was conducted. During the three (3) day tour of the facility, the surveyor observed and tested twelve (12) electrical outlets in wet (with-in 6 feet	K 911	that the GFCI outlets in the resident bathrooms are tested and de-energize as required by code or the outlets will be replaced. Element 3: The maintenance department were educated on K 911 regarding GFCI outlets installed within 6 feet of the outside of a sink. Element 4: The maintenance director/designee will conduct an audit on 10 rooms weekly for four weeks then 10 rooms monthly to ensure compliance with K911. Results of audits will be reported to the QAPI committee monthly for three months or 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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K 911	Continued From page 15 of a sink) locations with one (1) electrical outlet that failed to de-energize when tested in the following locations, On 11/28/2023: 1. At approximately 10:18 AM, inside the Resident room #421, one GFCI electrical outlet located thirteen inches (13") to the right of the bathroom hand washing sink when tested with a GFCI tester to de-energize, the GFCI electrical outlet did not de-energize as required by code. The US FOIA confirmed the findings at the time of observations. The US FOIA (b)(6) was informed of the deficiency during the survey exit on 11/30/2023 at approximately 11:45 AM. NJAC 8:39 -31.2 (e) NFPA 99: -6.3.2.1, NFPA 70: -210.8	K 911		
K 918 SS=E	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36	K 918		1/8/24

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K 918	Continued From page 16 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: REPEAT DEFICIENCY from 5/31/2023 survey. Based on interview and document review on 11/28/2023, 11/29/2023 and 11/30/2023, it was determined the facility failed to: - exercise the four (4) emergency generators for at least 30 minutes in 20- to 40-day intervals; and - document the time needed by the generator to transfer power to the building was within the 10-second time frame, accordance National Fire Protection Association (NFPA) 99 and 110. This deficient practice is evidenced by the following, Findings included:	K 918	Element 1: The generator load tests could not be corrected. Load tests were conducted in October and November and are currently up to date. Element 2: All residents have the potential to be affected by the deficient practice. The October and November load tests were reviewed, and the generators started and transferred power to the building within 10 seconds. Element 3:	

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K 918	Continued From page 17 On 11/28/2023 (day one of survey) during the survey entrance at 9:13 AM, a request was made to the US FOIA (b)(6) and US FOIA (b)(6) if the facility had an emergency generator. The US FOIA said, yes we have four (4) emergency generators here. Three (3) are for the Nursing home and One (1) generator is for the Dialysis Center. The surveyor asked the US FOIA does the facility document the load tests for the four (4) emergency generators (for the Nursing Home and Dialysis Center) and can the facility provide the logs for the last 6 months (June, July, August, September, October and November 2023) for review later. The US FOIA told the surveyor yes they have log books. On 11/29/2023 at approximately 8:59 AM a review of the four (4) "Emergency Generator Inspection Monthly Log" for the previous 6 months identified the following documented monthly load dates, - Generator A- 80 KW load dates, 6/30/2023, 7/03/2023 and 10/3/2023. - Generator B- 60 KW load dates, 6/30/2023, 7/03/2023 and 10/3/2023. - Generator C- 125 KW load dates, 6/30/2023, 7/03/2023 and 10/3/2023. - Generator D- 80 KW load dates, 6/30/2023, 7/03/2023 and 10/3/2023. There was no documented certification that the generator would start and transfer power to the building within ten seconds, since no load tests were conducted for August and September 2023. The US FOIA confirmed the findings at the time of documentation review.	K 918	Expectations of load testing were reviewed with the maintenance department on 12/26/2023, education on the subject matter was presented to the maintenance staff for review on 12/26/2023. Element 4: The NHA/designee will audit the generator load test log monthly for two months to ensure compliance with K 911. Results of audits will be reported to the QAPI committee monthly for three months or 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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K 918	Continued From page 18 The US FOIA (b)(6) was informed of the deficiency during the survey exit on 11/30/2023 at approximately 11:45 AM. NJAC 8:39-31.2(g)	K 918		

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 01 - MAIN BUILDING 01 B. Wing Y2	1/16/2024 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	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0281	01/08/2024	LSC K0353	01/08/2024	LSC K0355	01/08/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0363	01/08/2024	LSC K0521	01/08/2024	LSC K0911	01/08/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0918	01/08/2024	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
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	
12/12/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO