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 05/31/2023

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 This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
F 000	INITIAL COMMENTS Complaint # NJ00163045 & NJ00163818 SURVEY DATE: 05/31/23 CENSUS: 128 SAMPLE SIZE: 31 plus 3 closed records A Recertification Survey was Conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey. During a Standard Survey conducted on 05/31/23, it was determined that effective 05/16/23, the Facility was found to have been in Immediate Jeopardy for F689J, Part A. During a Standard Survey conducted on 05/31/23, it was determined that effective 05/24/23, the Facility was found to have been in Immediate Jeopardy for F698J, Part B. F698, s/s J, Part A On 05/16/23 at 12:25 PM, the facility failed to ensure Resident #22, a resident with a history of *Ex Order 26. 4B1* [redacted] received the appropriate *Ex Order 26. 4B1* [redacted] diet. This resulted in an Immediate Jeopardy (IJ) situation that began on 05/16/23 at 12:25 PM, when	F 000		

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

Electronically Signed | 06/22/2023

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F 000	Continued From page 1 Resident #22 was served the incorrect Ex Order 26. 4B1 sauerkraut without staff verifying the accuracy of the meal ticket at the time of meal plating and service to the resident. The facility's administration was notified of the IJ on 05/16/23 at 4:29 PM. The facility submitted an acceptable written Removal Plan on 05/16/23 at 7:37 PM. The survey team verified the implementation of the Removal Plan through observation and interview during the continuation of the on-site survey on 05/17/23. F689, s/s, Part B On 05/24/23 at 9:23 AM, the Life Safety Code (LSC) surveyor toured the Ex Order 26. 4B1 unit in the presence of the Maintenance Director (MD). At 10:18 AM, the LSC surveyor in the presence of the MD tested the water temperature in resident room Ex Order 2 on the Ex Order 26. 4B1 unit. The water temperature read 152 degrees Fahrenheit in the resident's bathroom. At 10:20 AM, the LSC surveyor in the presence of the MD went to another resident room and tested the water temperature. The facility's failure to maintain appropriate water temperatures placed residents on the Ex Order 26. 4B1 Unit at a likelihood of scalding or skin burns which could result in serious harm, impairment, or death. Vulnerable residents are more prone to burns due to decreased skin thickness, decreased skin sensitivity, peripheral neuropathy (loss of sensation in arms, hands, and lower limbs), reduced reaction time, decreased cognition, decreased mobility, and decreased communication. The facility's administration was notified of the IJ on 05/24/23 at 3:54 PM. The facility submitted an	F 000		

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F 000	Continued From page 2 acceptable written Removal Plan on 05/25/23 at 12:26 PM. The survey team verified the implementation of the Removal Plan during the continuation of the on-site survey on 05/25/23.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review,	F 609	Element 1:	6/14/23

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F 609	Continued From page 3 and review of other pertinent facility documentation, it was determined that the facility failed to report an allegation of *Ex Order 26. 4B1* to the New Jersey Department of Health (NJDOH) in accordance with state and federal guidelines. This deficient practice was identified for 2 of 5 residents, (Residents #31 and Resident #96) reviewed for abuse and was evidenced by the following: A review of the facility's deficient practice citation history from a survey that was conducted on 10/18/22 revealed the facility submitted a Plan or Correction (POC) to the NJDOH with a completion date of 11/07/22. The facility's POC indicated that staff were educated on abuse prevention and timely reporting. The POC further reflected that on 10/13/22 signage was posted throughout the facility and at the nurses' station to reinforce instructions on mandatory reporting of suspected or witnessed abuse, and who it should be reported to. On 05/22/23 at 10:37 AM, during a Resident Council meeting, Surveyor #1 met with Resident #96 who stated that while the residents were outside during activities, another resident came up to him/her and hit him/her on the *Ex Order 26. 4B1*. The resident could not remember the details of the event but was upset and felt that nobody did anything about it. The resident added that a "proctor" was outside with the residents during the activity, however, could not remember the staff member's name. On 05/22/23 at 11:15 AM, Surveyor #2 reviewed Resident #96's medical record which revealed the following:	F 609	R31 and R 96s incident was reported to the New Jersey Department of Health (NJDOH) and the New Jersey Long-Term-Care ombudsman on May 22, 2023. Emotional support was provided for both residents and are free from any signs/symptoms of distress related to the event. Element 2: All residents have the potential to be affected by this deficient practice. An audit was initiated on 5/23/2023 on incidents/unusual occurrences and allegations of abuse, neglect and/or misappropriation of property, and no other residents were affected. Element 3: On 5/23/2023 education was initiated for staff on reporting abuse/neglect immediately. On 5/23/2023 education was initiated for nursing supervisors/licensed nursing staff to ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown origins and misappropriation of resident property are reported immediately, but no later than two hours after the allegation is made or abuse is witnessed. Element 4: Executive Director/DON will audit all allegations of abuse to ensure compliance with F 609 and timely reporting requirements of alleged abuse allegations weekly for 4 weeks then monthly for one	

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F 609	Continued From page 4 According to the Admission Record (AR), Resident #96 was admitted to the facility with the diagnoses which included, but were not limited to, Ex Order 26. 4B1 [redacted]. Review of Resident #96's admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated 02/24/2023, reflected that the resident had Ex Order 26. 4B1 [redacted], no NJ Exec. Order 26:4.b.1 [redacted] and required NJ Exec. Order 26:4.b.1 with ADLs (activities of daily living). Review of Resident #96's Care Plan (CP) reflected that the resident had a Ex Order 26. 4B1 [redacted] on 05/20/23 and new interventions included a Ex Order 26. 4B1 [redacted] consult, a Ex Order 26. 4B1 [redacted] consult, NJ Exec. Order 26:4.b.1 [redacted] in the lounge and a NJ Exec. Order 26:4.b.1 [redacted] conducted on 05/22/23. Review of Resident #96's Nursing Progress Note (NPN), dated 5/20/2023 at 09:30 AM, indicated that Licensed Practical Nurse (LPN)#1 was in the hallway passing out medications and observed Resident #96 Ex Order 26. 4B1 [redacted] arguing with Resident #31 Ex Order 26. 4B1 [redacted]. LPN#1 documented that she rushed to separate the two residents when Resident #31 touched the Ex Order 2 [redacted] of Resident #96. Resident #96 was assessed by LPN#1 and there was no NJ Exec. Order 26:4.b.1 [redacted] noted on Resident #96's Ex Order 2 [redacted]. Resident #96 was educated by the nurse to keep his/her distance from Resident #31. LPN#1 documented that Resident #96 was in the dining area being supervised and that she initiated 15-minute checks for Resident #31.	F 609	month. The results of these audits will be reviewed during the monthly QAPI meetings.	

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F 609	Continued From page 5 Surveyor #2 reviewed the medical records for Resident #31 which revealed the following: According to the AR, Resident #31 was admitted to the facility with the diagnoses which included, but were not limited to, *Ex Order 26. 4B1* [redacted]. Review of the resident's quarterly MDS, dated 04/18/2023, reflected that the resident had *Ex Order 26. 4B1* [redacted]. The MDS also indicated that the resident had NJ Exec. Order 26:4.b.1 that occurred one to three days for NJ Exec. Order 26:4.b.1 directed toward others and other NJ Exec. Order 26:4.b.1 [redacted] not directed toward others. The MDS further indicated that the resident required NJ Exec. Order 26:4.b.1 with ADLs. Review of Resident #31's CP dated 11/07/2022, indicated a focus area that the resident had a risk for actual NJ Exec. Order 26:4.b.1 related to *Ex Order 26. 4B1* [redacted] as evidenced by NJ Exec. Order 26:4.b.1 *Ex Order 26. 4B1* directed toward others, placing items in the toilet and pacing. The CP also indicated that new interventions were initiated after the *Ex Order 26. 4B1* [redacted] of 05/20/23. The immediate interventions included separation of the two residents, 15-minute checks, *Ex Order 26. 4B1* Consult, *Ex Order 26. 4B1* Consult, telehealth conference with the attending physician, and medications changes. A NJ Exec. Order 26:4.b.1 was conducted on 05/22/23. Review of Resident #31's NPN, dated 05/20/2023 at 15:29 (03:29 PM), indicated that while LPN#2	F 609		

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F 609	Continued From page 6 was in the hallway conducting a medication pass, she observed Resident #31 arguing with another resident (Resident #96). As the nurse rushed to separate them, Resident #31 touched the [redacted] of Resident #96. The nurse documented that she educated the residents to keep their distance and that she initiated every 15-minute checks for Resident #31 throughout the shift. Family and primary care physician were notified. Review of a RER/R, dated 05/22/2023, reflected that on 05/20/2023 at 09:30 AM, while the Charge Nurse was in the hallway of the Court [redacted] Hallway [redacted] administering medications, she observed Resident #96 arguing with Resident #31. The nurse rushed to the residents to separate them, and the nurse observed Resident #31 touch Resident #96's [redacted]. According to the RER/R the residents were immediately separated, physical assessments were completed, Resident #31 was placed on 15-minute checks, both residents were to be seen by [redacted] and [redacted], and [redacted] were to be completed on both residents. On 05/22/23 at 12:18 PM, Surveyor #2 interviewed the Certified Nursing Aide (CNA) who stated that she had been employed in the facility for 15 years. The CNA stated that Resident # 96 was [redacted] but able to voice their needs and wants. She added that Resident #96 did not like anyone to touch his/her stuff and did not like other residents going in or out of his/her room. The CNA stated that Resident #96 did not complain or mention to her any incidents that might have occurred with the resident in the past couple of days. The CNA stated that when she received report that morning, the nursing staff did not report to her about any incident that may have	F 609		

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F 609	Continued From page 7 occurred with Resident #96 over the weekend (05/20/23-05/21/23). The CNA stated, "They just gave report regarding the care of the resident." She continued to add that Resident #96 would have NJ Exec. Order 26:4.b.1 when any other resident would wander into his/her room. At this time Surveyor #2 observed a fixed Ex Order 26. 4B sign attached across the resident's doorway. She described the Ex Order 2 sign as a deterrent for wandering residents and was an attempt to prevent residents that wander from entering Resident #96's room. On 05/22/23 at 12:39 PM, Surveyor #2 interviewed LPN#2 who stated that she had been employed in the facility for three months and had been working on Court Ex -unit Ex O side. She stated that she had worked the 7:00 AM - 3:00 PM shift and the 3:00 PM - 11:00 PM shift on 05/21/23. She stated that on Saturday, 05/20/23, she was informed that Resident #31 was an Ex Order 26. 4B1 and Ex Orde Resident #96 on the Ex Order 2. She continued to add that Resident #96 was Ex Orde on the Ex Order 26. and therefore the nursing staff was performing Ex Order 26. 4B checks (assesses an individual's Ex Order 26. 4B1 , Ex Order 26. 4B1 , and level of Ex Order 26. 4B1) for 72 hours. She also revealed that Resident #31 was put on 15-minute checks and that the nurses were signing it out on the Q15 minute check list. LPN#2 showed the surveyor 15-minute check list. LPN #2 stated that she was not sure how long the resident would remain on every 15-minute check. She stated that there had been no further incidents between the two residents. LPN#2 further stated that all Ex Order 26. 4B1 of abuse should be reported immediately and investigated. On 05/22/23 at 12:54 PM, Surveyor #2	F 609		

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F 609	Continued From page 8 interviewed the Director of Activities (AD) who stated that she was the manager on duty (MOD) for the weekend of 05/20/23 and 05/21/23. She stated that when an employee was MOD on the weekend that the MOD conducted rounds in the facility, assured that staffing was adequate, units were clean, and that residents were provided with the care that they needed. She stated that if anything happened with the residents while she was MOD, that she would handle it. The AD stated that no one reported to her on 05/20/23, that there was a Ex Order 26. 4B1 between Resident #96 and Resident #31. She stated that when she came into work on Monday 05/22/23, Resident #96 informed her that another resident Ex Order 26. 4B1, and that the resident reported the abuse to one of the CNAs (male) and the CNA walked away and said they would take care of it. She continued to add that if anything did happen while she was MOD over the weekend (05/20/23-05/21/23) then it should have been reported to her. She stated that she took the residents outside over the weekend with two other activities aides and there were no incidents with Resident #96 nor Resident #31 that occurred outside at activities. The AD stated that she reported the Ex Order 26. 4B1 of abuse to the Director Of Nursing (DON) at the morning meeting on 05/22/23. On 05/22/23 at 01:04 PM, Surveyor #2 interviewed the Activities Aide (AA #1) who indicated that she had supervised activities outside on 05/20/23 and 05/21/23 on the 7:00 AM - 3:00 PM shift. She stated that Resident #31 and Resident #96 were outside together but sitting apart and were a distance from each other. She stated that she was not aware of any Ex Order 26. 4B1 between the two residents and if she did then she	F 609		

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F 609	Continued From page 9 would have reported it. She stated that the residents were making flower arrangements and were getting along well and had a pleasant day. On 05/22/23 at 01:09 PM, Surveyor #2 interviewed the AA #2 for Court [redacted] who stated that she was not aware of any [redacted] between Resident #31 and Resident #96 outside at activities, however Resident #96 reported to her that Resident #31 [redacted] the other day (not specific about what day) and the resident asked her why that resident got to [redacted] (did not exactly know what the resident meant). AA #2 stated that she did not report Resident #96's [redacted] of abuse to anyone today because the resident stated that a staff member witnessed the [redacted], and she thought the resident was just voicing frustrations over the matter because it happened a couple days ago. AA #2 stated that if she witnessed an [redacted], she would have written an incident report. AA #2 also stated that any [redacted] of abuse should be reported to the DON immediately. On 05/22/23 at 01:52 PM, Surveyor #2 interviewed the DON who stated that she was made aware of the [redacted] between Resident #96 and Resident #31 by reviewing incident reports the morning of 05/22/2023. The DON stated that the nursing supervisor that was in the facility on 05/20/23 should have notified her that there was a [redacted] between Resident #96 and Resident #31 on 05/20/23 so that she could have notified the NJDOH and a RER/R could have been completed. The DON stated that the [redacted] should have been called into the NJDOH within two hours of the incident.	F 609		

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F 609	Continued From page 10 On 05/22/23 at 02:22 PM, Surveyor #2 conducted a telephone interview with the Registered Nurse Supervisor (RNS) who worked the weekend of 05/20/23 to 05/21/23 for the 7:00 AM - 3:00 PM shift. She stated that she was called to Court [redacted] unit and the nurse reported that Resident #31 had [redacted] Resident #96 in the [redacted]. She stated that both residents were immediately separated and that [redacted] were performed on both residents. She stated that Resident #96 had denied any pain or discomfort. She stated that Resident #31 was put on 15-minute checks and Resident #96 was started on [redacted]-checks for 72 hours because of being [redacted] in the [redacted]. She added that both families were notified by the nurse caring for the resident. She also stated the primary care physicians for both residents were notified regarding the incident. She then admitted that she did not notify the DON regarding the [redacted] between Resident #96 and Resident #31. She stated that she thought that the nurse on duty was going to notify the DON about the abuse. She added that she guessed it was just poor communication and that she should have notified the DON regarding any abuse incidents between two residents. She further stated that she did document the incident in the shift report. On 05/22/23 at 02:32 PM, Surveyor #2 attempted to conduct a telephone interview with LPN who worked 05/20/23 7:00 AM - 3:00 PM on Court [redacted] unit and witnessed the [redacted] between the two residents however there was no answer. The surveyor left a message. On 05/24/23 at 08:59 AM, Surveyor #2 interviewed the ED who stated that the facility	F 609		

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F 609	Continued From page 11 was responsible to report within two hours after any [Ex Order 26. 4B1] of abuse. Review of the facility policy, "Abuse Prevention," dated May 2008, indicated that all employees are expected to immediately report any sign of injury sustained by a resident whether the nature of the injury is known. Any employee witnessing any form of abuse is required to promptly report the incident to the nurse or nurse supervisor. The policy indicated that the facility must assure that any incidents of substantiated abuse and neglect are reported and analyzed and appropriate corrective, remedial, or disciplinary action occurs with applicable local, state, or federal laws. The policy indicated that the New Jersey Department of Health and Senior Services must be called immediately to report that the facility is investigating and allegation of abuse, neglect etc. NJAC 8:39-9.4 (f)	F 609		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to accurately code the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, in accordance with federal guidelines for 2 of 34 residents (Resident #22 and Resident #57) reviewed for accuracy of MDS coding.	F 641	Element 1: R57 Minimal Data Set (MDS) was corrected, and smoking status was updated on 5/18/2023. R22 Minimal Data Set was corrected on 5/23/2023, updating that he/she had [NJ Exec. Order 26:4.b.1] ordered. Element 2: An audit was conducted on 5/23/2023 to	6/14/23

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	315280	A. BUILDING _____ B. WING _____	C 05/31/2023

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F 641	Continued From page 12 This deficient practice was evidenced by the following: 1.) On 05/17/23 at 09:32 AM, the surveyor observed Resident #57 seated in his/her [redacted]. The resident told the surveyor that he/she had resided at the facility for about two and a half years, smoked cigarettes, and the facility's designated smoking times were 9:30 AM, 1:30 PM, 4:00 PM, and sometimes 6:30 PM depending on when dinner was done being served. The resident further told the surveyor that the facility staff kept his/her cigarettes and lighter when he/she wasn't smoking. On 05/18/23 at 01:36 PM, the surveyor observed the resident outside smoking with three other residents. Two staff members were present in the area helping the residents at the time of the surveyor's observation. The surveyor reviewed the medical record for Resident #57. A review of the resident's Admission Record (an admission summary) reflected that the resident was admitted to the facility in March 2017 and had diagnoses which included, but were not limited to [redacted]. A review of the resident's most recent annual MDS, dated 02/08/23, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15 which indicated the resident	F 641	ensure that no other resident□s MDS were coded incorrectly for [redacted] No other residents were affected. On 5/23/2023 residents who smoke audit was completed to ensure the MDS reflected smoking status. No other residents were affected. Element 3: On 6/9/2023 the RNAC department were educated on F 641 and the facility policy on smoking and [redacted] Element 4: The RNAC/designee will audit residents who smoke monthly for two months to ensure MDS reflect smoking status. The RNAC/designee will audit all resident ordered [redacted] to ensure MDS reflects [redacted] orders monthly for two months to ensure compliance. The results of the audits will be reported to the QAPI committee monthly until the committee determines that the issue is resolved or stable. The results will be used for additional training and system changes if necessary.	

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was *Ex Order 26. 4B1*. A further review of the resident's MDS, section J1300 - Current Tobacco Use indicated that the resident did not smoke.

A review of the resident's Quarterly/Annual/Significant Change Nursing Evaluation Packet, dated 05/03/23, indicated in Section IX Smoking/Nicotine Devices that the resident smoked cigarettes.

A review of the resident's Quarterly/Annual/Significant Change Nursing Evaluation Packet dated 02/07/22 indicated in Section IX Smoking/Nicotine Devices that the resident smoked cigarettes.

A review of the resident's Care Plan (CP), dated 03/21/22, reflected a focus area that the resident was a smoker. The goal of the CP was the resident would not smoke without supervision through the next review date. The interventions in the resident's CP included that the resident required supervision while smoking and the resident's smoking supplies were stored with activities.

On 05/18/23 at 01:59 PM, the surveyor interviewed the resident's Certified Nursing Aide (CNA #1) who stated the resident was NJ Exec. Order 26:4 [redacted] and smoked cigarettes.

On 05/18/23 at 02:00 PM, the surveyor interviewed the resident's Licensed Practical Nurse (LPN) who also stated that the resident was NJ Exec. Order 26:4.b.1 [redacted], and smoked cigarettes.

On 05/18/23 at 02:01 PM, the surveyor interviewed Registered Nurse/Minimum Data Set

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F 641	Continued From page 14 Coordinator (RN/MDSC) #1 who stated that Resident #57's MDS was coded in error because the resident was a smoker. On 05/31/23 at 09:38 AM, in the presence of the survey team, the surveyor interviewed the facility's Executive Director (ED) who stated that the resident's MDS was updated to reflect that the resident smoked. A review of CMS RAI Version 3.0 Manual, Section J - Health Conditions indicated in J1300: Current Tobacco Use, that the negative effects of smoking can shorten life expectancy and create health problems that interfere with daily activities and adversely affect quality of life. In planning for care, this item opens the door to negotiation of a plan of care with the resident that includes support for smoking cessation. If cessation is declined, a care plan that allows safe and environmental accommodation of resident preferences is needed. Facility staff is to conduct an assessment and ask the resident if he or she used tobacco in any form during the seven (7) day look-back period. If the resident states that he or she used tobacco in some form during the 7-day look-back period, code 1, yes. If the resident is unable to answer or indicates that he or she did not use tobacco of any kind during the look-back period, review the medical record and interview staff for any indication of tobacco use by the resident during the look-back period. Coding Instructions indicated to code "0" for no, indicating the resident did not smoke and "1" for yes, indicating that the resident did smoke. 2.) On 05/19/23 at 10:35 AM, the surveyor observed Resident #22 self-propelling his/her Ex Order 26. 4B1 on the unit. The resident did not have	F 641		

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any [NJ Exec. Order 26:4.b.1] visible.

According to the Admission Record, Resident #22 had diagnoses which included, but were not limited to, *Ex Order 26. 4B1*.

Review of the resident's quarterly MDS, dated 03/22/23, included the resident had a BIMS score of [redacted] out of 15, which indicated that the resident's cognition was *Ex Order 26. 4B1*. Further review of the MDS revealed the resident had a [redacted] used less than daily.

Review of the resident's Care Plan did not indicate the resident had a [NJ Exec. Order 26:4.b.1]

Review of the resident's Physician's Order Form, dated 05/2023, did not include a physician's order for a [NJ Exec. Order 26:4.b.1]

Review of the resident's MDS Kardex Report, undated, did not indicate the resident had a [NJ Exec. Order 26:4.b.1]

Review of the resident's *Ex Order 26. 4B1* and *Ex Order 26. 4B1* Discharge Summaries, dated 01/19/23 - 04/04/23, did not indicate the resident had a [NJ Exec. Order 26:4.b.1].

On 05/22/23 at 8:15 AM, the surveyor interviewed CNA #2, who was assigned to Resident #22, who stated that the she did not have any residents with [NJ Exec. Order 26:4.b.1] on her assignment. CNA #2 further stated that she would know which residents had a [NJ Exec. Order 26:4.b.] based on the Kardex.

On 05/23/23 at 10:44 AM, the surveyor interviewed RN/MDSC #1 who stated she determined which residents had a [NJ Exec. Order 26:4.b.] based

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F 641	Continued From page 16 on the documentation in the resident's medical record and from communication with the [Ex Order 26. 4B1] Director, who kept a log of resident [NJ Exec. Order 26:4.b.1] When asked about Resident #22, RN/MDSC #1 stated the resident never had a [NJ Exec. Order 26:4.b.1] and that RN/MDSC #2 may have "miscoded" the MDS assessment. On 05/23/23 at 10:56 AM, the surveyor interviewed the [Ex Order 26. 4B1] Director who confirmed that Resident #22 did not have a [NJ Exec. Order 26:4.b.1] On 05/24/23 at 8:57 AM, the surveyor interviewed RN/MDSC #2 who stated Resident #22 never had a [NJ Exec. Order 26:4.b.1] and that she, "clicked the wrong button by mistake". On 05/26/23 at 10:48 AM, the surveyor interviewed the Director of Nursing (DON) who stated the RN/MDSCs should complete the MDS assessments accurately. Review of CMS RAI Version 3.0 Manual, Section P - Restraints and Alarms indicated in P0100: Review the resident's medical record (e.g., physician orders, nurses' notes, nursing assistant documentation) to determine if physical restraints were used during the 7-day look-back period. Review of the MDS Coordinator Job Description, revised 11/2015, included, "Be familiar with residents' condition and care needs," and, "Complete reports and assignments accurately and adhere to established time schedules." NJAC 8:39-11.2(e)1	F 641		
F 644 SS=E	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2)	F 644		6/14/23

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F 644	Continued From page 17 §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documentation it was determined that the facility failed to conduct a new Preadmission Screening and Resident Review (PASARR) Level 2 (two) assessment after residents who were diagnosed with a [redacted] after admission to the facility for 2 of 2 residents (Residents #20 and #57) reviewed for the PASARR requirement and was evidenced by the following: 1.) On 05/18/23 at 09:00 AM, the surveyor observed Resident #20 in his/her room and was [redacted] dependent. The resident indicated that he/she felt ok and had no complaints or concerns.	F 644	Element 1 R20s assessment was completed 6/15/2023 with [redacted] who is the [redacted] via telehealth video conference. [redacted] assessment is currently in [redacted] medical record. R57 assessment for [redacted] will be conducted [redacted] at 2:00pm via telehealth. After the information is received from the [redacted] it will be sent to the state for review. Element 2 On 5/18/2023 the [redacted] department initiated an audit on all [redacted] PASRRs to ensure accuracy and	

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F 644	Continued From page 18 The surveyor reviewed the medical record for Resident #20. The Admission Record (AR) indicated that Resident #20 was admitted to the facility with diagnoses which included, but were not limited to, [redacted]. The Annual Minimum Data Set (MDS), an assessment tool that is utilized to facilitate care for residents dated 04/12/23, indicated that the resident was not considered for the PASARR [redacted] process because the resident did not have a serious [redacted] and or [redacted] or related condition, however the MDS reflected that the resident had the diagnoses of [redacted]. The MDS also reflected that the resident was [redacted] and usually understood verbal and nonverbal expression. On 05/18/23 at 09:18 AM, the surveyor reviewed the PASARR [redacted] which was completed 01/17/2018, and indicated that the resident did not have any major [redacted] such as [redacted] disorder that may lead to chronic disability. The surveyor reviewed the Medication Management Assessment/Psychiatric Consult (MMAPC) dated 09/20/2019, which reflected that the [redacted] had examined the resident and diagnosed the resident with [redacted]. The MMAPC also indicated that the resident had [redacted].	F 644	completion. Element 3 The facility reviewed the policy on PASARRs and revised the PASARR process. A group email will be initiated to alert all members of the Interdisciplinary Team (IDT) that a [redacted] diagnosis has been added or changed. This will alert the RNAC, Nursing, and the Social Services Department to initiate the appropriate [redacted] PASARR process. The RNAC, Admission Department, External Liaisons, and Social Services Department were educated (initiated on 5/31/2023) on F 644 to ensure the appropriate coordination with State designated authority, to ensure that individuals with a [redacted] or related condition receives care and services in the most integrated setting appropriate to their needs. Element 4 The Social Services Director/designee will audit 4 residents weekly for 8 weeks [redacted] visits to ensure any medication or diagnosis changes that require a [redacted] PASARR are reflected and a [redacted] PASARR will be initiated if applicable. 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.	

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F 644	Continued From page 19 A further review of the resident's AR diagnoses information section reflected that Resident #20 was diagnosed with a Ex Order 26. 4B1 on 06/30/2020. The surveyor reviewed Resident #20s most recent Ex Order 26. 4B1 consult dated 05/18/23 which indicated that Resident #20 continued to have Ex Order 26. 4B1 . On 05/18/23 at 09:26 AM, the surveyor interviewed the Registered Nurse Unit Manager for the Ex Order 26. 4B1 unit who stated that the resident had a Ex Order 26. 4B1 . She explained that the resident would frequently ask the staff Ex Order 26. 4B1 or Ex Order 26. 4B1 . She also stated that the resident had NJ Exec. Order 26:4.b.1 . She stated that the resident would NJ Exec. Order 26:4.b.1 at times. She stated that the resident also had Ex Order 26. 4B1 and worried a lot. She continued to explain that the resident experienced Ex Order 26. 4B1 On 05/18/23 at 10:19 AM, the surveyor interviewed the Director of Social Work (DSW) who indicated that Resident #20 should have had a PASARR Ex Order 26. 4B1 completed after being diagnosed with a Ex Order 26. 4B1 and that Ex Order contacted a Ex Order 26. 4B1 company that the facility contracted with so that they could perform the PASARR Ex Order 26. 4B1 She stated that after they perform the PASARR Ex Order 26. 4B1 that she would then	F 644		

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F 644	Continued From page 20 contact the appropriate state-designated authority and send the completed PASARR Ex Order 26. 4B1 to the Division of Developmental disabilities (DDD) and/or the Division of Mental Health and Addiction Services (DMHAS) as appropriate. She stated that since she started employment in the facility, she started a quality improvement (QI) about PASARR Ex Order 26. 4B1 completion and had been trying to assure that any resident that needed a PASARR Ex Order 26. 4B1 would be scheduled to have one. The Ex Order 26. 4B1 company was scheduled to come on Friday (05/19/23) to complete the PASARR Ex Order 26. 4B1 The DSW showed the surveyor the correspondence with the Ex Order 26. 4B1 company regarding coming into the facility to perform the PASARR Ex Order 26. 4B1 on residents that were diagnosed with a Ex Order 26. 4B1 after admission to the facility. On 05/23/23 at 11:20 AM, the surveyor interviewed the MDS Coordinator who stated that when the resident was diagnosed with a new Ex Order 26. 4B1, the SW should have notified her so that a new PASARR Ex Order 26. 4B1 could have been completed. She stated that after the PASARR Ex Order 26. 4B1 was completed, that it would have triggered a PASARR Ex Order 26. 4B1 to be completed and sent to the appropriate authority. She stated that it would have been important to make sure that these were completed to ensure that the resident received the appropriate services. The MDS Coordinator stated that she could not speak to what happened in the past but moving forward all resident PASARRs would be checked to assure that there were no newly diagnosed residents with a major Ex Order 26. 4B1 in the facility that would have required a PASARR Ex Order 26. 4B1 to be completed.	F 644		

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F 644	Continued From page 21 On 05/31/23 at 09:30 AM, in the presence of the survey team the Executive Director (ED) stated that Resident #20 was originally admitted in [redacted] and could not speak to what happened back in that time and did not know if the resident had a PASARR [redacted] or PASARR [redacted] back in 2010, but going forward the SW had identified that there were issues with residents having been diagnosed with a major [redacted] after admission and [redacted] PASARRs that needed to be completed. On 05/31/23 at 09:51 AM, in the presence of the survey team, the surveyor interviewed the DSW who stated that the importance of the PASARR [redacted] was to make sure the resident was suitable for the nursing home placement and to see if the resident had [redacted] diagnoses that may have required special services or care related to their [redacted] diagnoses. The DSW stated that if a resident was diagnosed with a major [redacted] after admission then a change of condition would have to be completed and the PASARR [redacted] would be updated to reflect the specific [redacted] diagnoses. She continued that if the new diagnoses was given in the facility that a new CP would be instituted to reflect the new diagnoses. The DSW further stated, "We did see this as a concern and an ongoing Quality Assurance & Performance Improvement (QAPI) was being done." 2.) On 05/17/23 at 09:32 AM, the surveyor observed Resident #57 seated in his/her [redacted]. The resident told the surveyor that he/she had resided at the facility for about two and a half years. The surveyor reviewed the medical record for	F 644		

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F 644	Continued From page 22 Resident #57. A review of the resident's Admission Record (an admission summary) reflected that the resident was admitted to the facility in Ex Order 26. 4B1 and had diagnoses which included but were not limited to Ex Order 26. 4B1 [redacted]. A review of the resident's most recent quarterly MDS dated 05/03/23, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15 which indicated the resident was Ex Order 26. 4B1. A further review of the resident's MDS, Section I - Active Diagnoses revealed that the resident had a diagnosis of Ex Order 26. 4B1 [redacted]. A review of the resident's PASARR Ex Order 26. 4B1 Screen dated 03/15/17, indicated the resident did not have any major NJ Exec. Order 26:4.b.1 such as Ex Order 26. 4B1 [redacted]. A review of a Report of Consultation dated 04/07/17, indicated that the resident had been suffering from Ex Order 26. 4B1 [redacted] type for many years and was currently Ex Order 26. 4B1. A review of the Medication Management	F 644		

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F 644	Continued From page 23 Assessment completed by a Ex Order 26. 4B1 practitioner dated 11/19/19, further indicated that the resident had a history of Ex Order 26. 4B1 [redacted] for many years and had been under the care of a Ex Order 26. 4B1 for approximately 10 years. The Medication Management Assessment further discussed the resident's personal Ex Order 26. 4B1 history and the medication he/she was receiving to treat their Ex Order 26. 4B1. A review of the resident's Care Plan dated 02/20/23, indicated a focus area that the resident had a diagnosis of Ex Order 26. 4B1 [redacted]. The goal of the resident's Care Plan was the resident would have improved NJ Exec. Order 26:4.b.1 by reporting adequate rest or documented episodes of Ex Order 26. 4B1 less than weekly through the next review date. The interventions in the resident's Care Plan included to monitor the resident's Ex Order 26. 4B1 [redacted], and report to medical doctor. On 05/22/23 at 11:09 AM, the surveyor interviewed the DSW who stated that if a resident was diagnosed with a Ex Order 26. 4B1 after admission to the facility, during the quarterly care conference the team would go back and usually change the PASARR. The DSW stated that the MDS Coordinator would notify her of the change, and she would initiate a new PASARR. The DSW further stated the importance of completing the PASARR Ex Order 26. 4B1 was to ensure that the resident's needs were being met related to a Ex Order 26. 4B1 diagnosis and care would be implemented and performed related to that. On 05/22/23 at 12:18 PM, the surveyor interviewed the MDS Coordinator who stated that	F 644		

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F 644	Continued From page 24 the resident was admitted to the facility with a Ex Order 26. 4B1 and although it was not on the PASARR Ex Order 26. 4B1, it was documented on the resident's first MDS. The MDS Coordinator further stated that if it was identified that the resident had a Ex Order 26. 4B1 such as Ex Order 26. 4B1 upon admission and the PASAAR Ex Order 26. 4B1 was Ex Order 26. 4B1, the PASARR Ex Order 26. 4B1 should have still been completed. The MDS Coordinator told the surveyor that if she identified the resident had a Ex Order 26. 4B1 upon admission that would require a PASARR Ex Order 26. 4B1 to be completed, she would notify the DSW. The MDS Coordinator stated that she couldn't speak to why a PASARR Ex Order 26. 4B1 was not performed for the resident and that the PASARR Ex Order 26. 4B1 should have been completed. On 05/31/23 at 09:40 AM, the surveyor interviewed the ED who stated that he did not think it was a concern because the Ex Order 26. 4B1 diagnosis was captured on the initial MDS. The ED further stated that he was unable to explain why the PASARR Ex Order 26. 4B1 was not completed for Resident #57. A review of the facility's Preadmission Screening and Annual Resident Review (PASARR) Policy revised 08/22 indicated, "This facility promotes and supports a resident centered approach to care. The purpose of this policy is to define and set expectations regarding the appropriate preadmission assessment of all individuals with a Ex Order 26. 4B1 and individuals with NJ Exec. Order 26:4.b.1 It is the policy of the facility to coordinate the assessment process with the preadmission screening and annual resident review (PASARR) program under Medicaid in Subpart C to the extent practicable to avoid	F 644		

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F 644	Continued From page 25 duplicate testing and effort. This includes incorporating the recommendations from the PASARR Ex Order 26. 4B1 determination and evaluation of the residents' assessment, care plan, and transition of care; and referring all Ex Order 26. 4B1 residents and all residents with new or evident conditions related to Ex Order 26. 4B1 review upon significant change in status assessment." The facility's PASARR Policy further indicated, "The facility will refer all Ex Order 26. 4B1 residents and all residents with newly evident or possible serious *Ex Order 26. 4B1*, or related condition for a Ex Order 26. 4B1 review upon a significant change in status assessment to the State PASARR representative." NJAC 8:39.5.1(a)	F 644		
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	F 656		6/14/23

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F 656	Continued From page 26 under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (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: Complaint #NJ00163818 Based on interview, record review and review of pertinent facility documentation it was determined that the facility failed to develop a Comprehensive Care Plan for the care of a resident's [redacted]. This deficient practice was identified for 1 of 34 residents, (Resident #232) reviewed for the Comprehensive Care Plans and was evidenced by the following.	F 656	Element 1: Resident 232 no longer resides at the facility. Element 2: Any resident can be affected by the deficient practice. All residents with dentures were audited to ensure they have a care plan in place. Element 3:	

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F 656	Continued From page 27 On 05/25/23 at 10:49 AM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM) who stated that when a resident was admitted to the facility, an inventory sheet would be included in the resident's medical record documenting all the personal items that the resident brought into the facility. The LPN/UM did not speak to personal items that would be documented on the resident's Admission Assessment. The LPN/UM stated that after Resident #232 was discharged from the facility, the resident representative visited the facility for the resident's belongings, and she provided the resident representative with Ex Order 26. 4B1 that she thought belonged to Resident #232. On 05/25/23 at 11:07 AM, the surveyor conducted an interview over the telephone with the resident representative who stated that the resident was admitted to the facility with *Ex Order 26. 4B1* and came to the facility wearing them. The resident representative stated that after the resident was discharged from the facility, the LPN/UM provided the resident representative with *Ex Order 26. 4B1* that she thought could have been the residents, but unfortunately, they did not fit the resident and according to the resident representative, they must have belonged to someone else. The resident representative stated that he/she had not been in contact with the facility but was going to bring back the Ex Order 26. 4B1 that didn't fit the resident. The surveyor reviewed the closed medical record for Resident #232. A review of the resident's Admission Record (an Admission Summary) reflected that the resident was admitted to the facility on Ex Order 26. 4B1, had since been discharged from the facility and had	F 656	The ADON in-serviced the nursing staff on the facilities protocol of care planning residents that come in with Ex Order 26. 4B1. This in-service was conducted on 6/2/23. Element 4: ADON/Designee will audit 5 residents weekly x 4 weeks new/ re admissions with Ex Order 26. 4B1 to ensure a care plan is in place then monthly x 1 months. These results will be reviewed at the facilities QA meeting monthly. The QA committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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F 656	Continued From page 28 diagnoses which included but were not limited to [redacted]. A review of the resident's admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated, 04/03/23 indicated that the resident's cognitive skills for decision making were [redacted]. A review of the resident's New Jersey Universal Transfer Form dated [redacted], indicated that the resident was not sent from the facility to the [redacted] with [redacted]. A review of the resident's Admission/Readmission Nursing Evaluation, Section X. dated 03/28/23, Oral/Dental Evaluation indicated that the resident had full [redacted] when he/she was admitted to the facility. A review of the resident's Comprehensive Care Plan dated 03/29/23, indicated that the resident did not have a Care Plan in place for the care of their [redacted]. On 05/25/23 at 12:09 PM, the surveyor interviewed Certified Nursing Aide (CNA)#1 who had cared for the resident. CNA#1 stated that the resident was [redacted] with [redacted], walked a little [redacted], and to her knowledge, was unsure if the resident wore [redacted]. CNA#1 told the surveyor that if the resident wore [redacted], the staff would put them in for the resident in the morning. CNA#1 told the surveyor that if the resident's [redacted] went missing, she would inform the nurse.	F 656		

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F 656	Continued From page 29 On 05/25/23 at 12:12 PM, the surveyor interviewed CNA#2 who remembered the resident when the surveyor showed her a picture of him/her. CNA#2 stated that the resident was pleasant and would feed himself/herself during meals. CNA#2 told the surveyor that she was unsure if the resident had Ex Order 26. 4B1. CNA#2 told the surveyor that if a resident had Ex Order 26. 4B1, the 7:00 AM - 3:00 PM CNA would receive the Ex Order 26. 4B1 from the nurse and put them in the resident's mouth. CNA#2 further explained the 3:00 PM - 11:00 PM CNA would remove them from the resident's mouth, clean them, and give them to the nurse to lock up in the medication cart. On 05/25/23 at 12:17 PM, the surveyor interviewed CNA#3 who stated that she never took care of the resident but recalled that the resident was Ex Order 26. 4B1 and would walk around the unit. CNA#3 told the surveyor that if a resident had Ex Order 26. 4B1, the Ex Order 26. 4B1 would be soaked and cleaned at nighttime and then put into the resident's mouth in the morning. CNA#3 stated that for the most part, the Ex Order 26. 4B1 were kept in the resident's rooms. CNA#3 further stated that if a resident's Ex Order 26. 4B1 were lost, she would notify the LPN/UM and Ex Order 26. 4B1 would be included in the residents Care Plan. On 05/26/23 at 10:02 AM, the surveyor interviewed the resident's Licensed Practical Nurse (LPN) who stated that if a resident came into the facility on admission and had Ex Order 26. 4B1, it would be captured in the admission evaluation in the section that assessed oral and dental health. The LPN explained that the process for when a resident had Ex Order 26. 4B1 was the CNAs would help	F 656		

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F 656	Continued From page 30 the resident put them in their mouth in the morning and the nurse would lock the [Ex Order 26. 4B1] in the medication cart at night. The LPN further stated that it was easy for the residents on the unit to lose their [Ex Order 26. 4B1] due to their diagnoses of [Ex Order 26. 4B1]. The LPN stated that if a resident had [Ex Order 26. 4B1], the care of them would be expected to be documented in the resident's care plan. On 05/26/23 at 10:13 AM, the surveyor conducted a follow up interview with the LPN/UM who stated that if the resident wore [Ex Order 26. 4B1], it would be included in their plan of care On 05/26/23 at 12:25 PM, the surveyor interviewed the Executive Director in the presence of the survey team who stated that if the facility was culpable of losing the item, they would do a, "check request reimbursement" and the facility's corporate office would provide reimbursement to the resident and family. On 05/31/23 at 09:48 AM, the surveyor interviewed the facility's Director of Nursing who stated that the care of the [NJ Exec. Order 26:4.b.1] would be something that should be included in the plan of care and the admitting nurse or unit manager were responsible for creating the care plan for the resident. A review of the facility's Care Plan Policy and Procedure dated May 2022, indicated that it was the policy of the facility, "that all residents admitted to the facility would be provided adequate person-centered care plans that provide for all their needs in a timely manner." NJAC 8:39-11.2(e)1,2	F 656		

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F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Complaint #NJ00163818 Based on interview, facility closed record review, and hospital record review it was determined that the facility failed to remove a hospital bracelet from a resident's wrist. This deficient practice was identified for 1 of 34 resident's, (Resident #232) reviewed for quality of care and was evidenced by the following: On 05/25/23 at 11:07 AM, the surveyor interviewed Resident #232's resident representative who told the surveyor that he/she was present in the Emergency Room (ER) when the resident was sent from the facility to the hospital. The resident representative further stated that the resident's hospital bracelet from their previous hospitalization was still attached to the resident's wrist and had not been removed at the facility. The surveyor reviewed the facility's closed medical record for Resident #232. A review of the resident's Admission Record (an Admission Summary) reflected that the resident	F 684	Element 1: Resident # 232 no longer resides at this facility. Element 2: Any resident admitted/readmitted from the hospital can be affected by the deficient practice. All residents admitted/readmitted to the facility within the last 30-days were audited. Element 3: The ADON in-service nursing staff on the facilities protocol of removing arm bands upon admission/readmission. This in-service was conducted on 4/24/23. Element 4: ADON/Designee will audit 5 residents' admission/readmission weekly x 4 weeks than 8 residents monthly. Audits/Observations will be conducted randomly. DON/Designee is responsible for the compliance audit. Findings will be presented to the QA committee monthly until 100% compliance is achieved x 3	6/14/23

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F 684	Continued From page 32 was admitted to the facility on Ex Order 26. 4B1, and had since been discharged from the facility. The Admission Record further revealed the resident had diagnoses which included but were not limited to Ex Order 26. 4B1 [redacted]. A review of the resident's admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated 04/03/23, indicated that the resident's cognitive skills for decision making were Ex Order 26. 4B1 . A review of the New Jersey Universal Transfer Form reflected that the resident was sent from the facility to the NJ Exec. Order 26:4.b.1 [redacted] for a change in NJ Exec. Order 26:4 [redacted] and Ex Order 26. 4B1 on Ex Order 26. 4B1 at 12:24 PM. A review of the resident's Progress Notes (PN) reflected a PN written by the Nurse Practitioner (NP) dated NJ Exec. Order 26:4.b [redacted] and timed at 15:33 (3:33 PM). The PN revealed that the Licensed Practical Nurse (LPN) notified the NP that the resident had increased Ex Order 26. 4B1 [redacted]. The PN further indicated that the NP called another physician to discuss the resident's condition and the two physicians' along with the family agreed to send the resident to the NJ Exec. Order 26:4.b [redacted] for an evaluation. A review of the resident's Care Plan dated 03/29/23, reflected a focus area that the resident was at risk for Ex Order 26. 4B1 and Ex Order 26. 4B1 related to medications that Ex Order 26. 4B1 and Ex Order 26. 4B1 . The goal of the residents Care Plan revealed that the resident would not develop	F 684	consecutive months. The QA committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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F 684	Continued From page 33	F 684		

Ex Order 26. 4B1 till the next review date. Interventions within the residents Care Plan included to keep NJ Exec. Order 26:4.b.1

A further review of the resident's Care Plan reflected that the resident was on an *Ex Order 26. 4B1* [redacted]. The goal of the residents Care Plan indicated that the resident would be free from discomfort or adverse reactions related to *Ex Order 26. 4B1* use through the next review date. The interventions in the resident's Care Plan included daily NJ Exec. Order 26:4.b.1 and report abnormalities to the nurse.

A complete review of the resident's closed facility medical record did not indicate that the facility staff removed the resident's hospital bracelet upon admission to the facility or that facility staff was evaluating the resident's skin on his/her *Ex Order 26. 4B1* [redacted] daily as the resident's Care Plan specified.

The surveyor reviewed the closed hospital medical record for Resident #232.

A review of the resident's Emergency Departments Admission Record reflected that the resident was admitted to the [redacted] on *Ex Order 26. 4B1* with diagnoses which included but were not limited to *Ex Order 26. 4B1* [redacted].

A review of the initial Emergency Department History and Physical (H&P) indicated that per Emergency Medical Services (EMS), Resident #232 was found at the facility *Ex Order 26. 4B1* [redacted]. The Emergency Department H&P

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F 684	Continued From page 34 further indicated that the EMS told the medical personnel working in the ER the resident was wearing an old hospital bracelet. A review of the ER Registered Nurse (RN) notes dated [NJ Exec. Order 26:4] and time at 1323 (1:23 PM) indicated, "*Ex Order 26. 4B1* noted after removal of old patient ID [identification] bracelet with name no longer visible. Awaiting diagnostic studies.". This PN indicated that the resident's hospital bracelet was located on the resident's *Ex Order 26. 4B1*. A review of imaging results from an [Ex Order 26.] dated [NJ Exec. Order 26:4.], reflected that the resident's had no *Ex Order 26. 4B1* of the [Ex Orde]. A review of the closed hospital record did not reflect that the resident had an [Ex Order 26.] taken of his/her *Ex Order 26. 4B1*. A review of the Medical Doctor's (MD) H&P dated [NJ Exec. Order 26:4.b.1] at 8:46 PM, reflected that the resident was wearing an old hospital bracelet upon admission to the ER and when the hospital bracelet was removed, there was *Ex Order 26. 4B1* on the resident's [Ex Order 26]. The MD documentation did not specify which wrist the hospital bracelet was located on and removed from. A review of the Licensed Social Workers (SW) evaluation and PNs dated [NJ Exec. Order 26:4.b.1] at 9:00 AM, reflected that the ER documentation indicated that the resident had *Ex Order 26. 4B1* related to the hospital bracelet that was not removed at the facility. A review of a black and white picture of Resident	F 684		

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F 684	Continued From page 35 #232's hospital bracelet taken in the ER on [NJ Exec. Order 26:4.b.1], revealed a white, long, rectangular hospital bracelet that had been cut off the resident's [Ex Order 26]. There was a gloved hand in the picture. The gloved hands thumb was at the bottom of the hospital bracelet and the middle finger was stretched out, touching the top of the hospital bracelet. The picture indicated that the white hospital bracelet had black smudges throughout, where it had been in contact with the resident's [Ex Order 2]. The picture revealed that the hospital bracelet had to be stretched out to prevent it from curling up at the edges. This was evident in the picture due to the area in front of the gloved hands thumb curling at the top. The surveyor continued to review the pictures taken in the ER on [NJ Exec. Order 26:4.b.1] an additional picture reflected the hospital bracelet placed on a counter and curled up. The outside of the hospital bracelet was white and depicted fewer black smudges then the previous picture. There was no observable writing on the hospital bracelet. The inside of the resident's hospital bracelet revealed that the hospital bracelet had black smudges throughout, the same as the previous picture. A review of a picture of Resident #232's [Ex Order 26] and [Ex Order 26. 4B1] taken in the ER on [NJ Exec. Order 26:4.b.1], indicated that there was *Ex Order 26. 4B1* on the resident's [Ex Order 26]. The outline of the *Ex Order 26. 4B1* was consistent with the shape and size of the pictures of the hospital bracelet. NJAC 8:39-27.1(a)	F 684		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3)	F 688		6/14/23

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	315280	A. BUILDING _____ B. WING _____	C 05/31/2023

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F 688	Continued From page 36 §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of facility documentation, it was determined that the facility failed to appropriately apply physician ordered *Ex Order 26. 4B1* to a resident with *Ex Order 26. 4B1* related to *Ex Order 26. 4B1* [redacted]. This deficient practice was identified for 1 of 2 resident's, (Resident #68) reviewed for position and *Ex Order 26. 4B1* and was evidenced by the following: On 05/17/23 at 09:24 AM, the surveyor observed Resident #68 lying in bed on an *Ex Order 26. 4B1*. The surveyor further observed that the resident was wearing NJ Exec. Order 26:4.b.1 on both of his/her hands. The surveyor did not observe the resident wearing a *Ex Order 26. 4B1* on his/her *Ex Order 26. 4B1*. At the time of the observation, the surveyor	F 688	Element 1: Resident # 68 was provided with [redacted] No adverse effect was noted. Element 2: Any resident can be affected by the deficient practice. All residents with *Ex Order 26. 4B1* were audited to ensure they had *Ex Order 26. 4B1* on. Element 3: The ADON will in-service the nursing staff on the facility protocol of NJ Exec. Order 26:4.b.1 on 6/14/23. Element 4. The therapy Department will audit weekly x four weeks residents with [redacted] to ensure the resident is wearing the [redacted]	

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F 688	Continued From page 37 attempted to interview the resident. The resident was [NJ Exec. Orde] with his/her eyes, but [NJ Exec. Order 26:4.b.1] communicate. On 05/18/23 at 11:30 AM, the surveyor observed the resident laying in bed with a [Ex Order 26. 4B1] on the residents [Ex Order 26. 4B1] and a [Ex Order 26. 4B1] attached to the resident's [Ex Order 26. 4B1] which extended up his/her [Ex Order 26. 4B1]. The surveyor did not observe a [Ex Order 26. 4B1] or a [Ex Order 26. 4B1] on the resident's [Ex Order 26. 4B1]. On 05/19/23 at 11:01 AM, the surveyor observed the resident laying in bed wearing a [Ex Order 26. 4B1] on his/her [Ex Order 26. 4B1] and a [Ex Order 26. 4B1] attached to the resident's [Ex Order 26] which extended up his/her [Ex Order 26. 4B1]. At the time of the observation, the surveyor did not observe that the resident was wearing a [Ex Order 26. 4B1] on his/her [Ex Order 26. 4B1] The surveyor reviewed the medical record for Resident #68. A review of the resident's Admission Record (an admission summary) reflected that the resident was admitted to the facility in [Ex Order 26. 4B1] and had diagnoses which included but were not limited to [Ex Order 26. 4B1]. A review of the resident's quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated 04/12/23, indicated that the resident's cognitive skills for decision making were [Ex Order 26. 4B1]. A further resident's MDS, Section G0400 - [Ex Order 26. 4B1] indicated that the	F 688	then monthly x 1 month. These results will be reviewed at the facilities QA meeting monthly. The QA committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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F 688	Continued From page 38 resident had NJ Exec. Order 26:4.b.1 on both Ex Order 26. in their Ex Order 26. 4B1 [redacted] A review of the resident's February 2023 Physician Order Sheet (POS) reflected a Physician Order (PO) dated 02/19/23, for Ex Order 26. 4B1 [redacted]. Donn (put on) in the AM and remove prior to PM care. Monitor NJ Exec. Order 26:4.b.1 and provide hand hygiene. A review of the March 2023 POS revealed a PO dated 03/30/23, for the resident to tolerate Ex Order 26. 4B [redacted] daily after AM care as tolerated, remove at nighttime. Nursing to provide NJ Exec. Order 26:4.b.1 and hand hygiene. A review of the May 2023 Physician Order Form did not indicate a PO for the use of the Ex Order 26. 4B1 [redacted]. A review of the resident's May 2023 Treatment Administration Record (TAR) revealed a PO dated 03/30/23, for the resident to tolerate Ex Order 26. 4B [redacted] daily after AM care as tolerated. Remove at nighttime. Nursing to provide NJ Exec. Order 26:4.b.1 and hand hygiene. A further review of the May 2023 TAR reflected that the nurses were signing for the treatment for the Ex Order 26. 4B1 [redacted] on the 7:00 AM - 3:00 PM shift, the 3:00 PM - 11:00 PM shift, and the 11:00 PM - 7:00 AM shift.	F 688		

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F 688	Continued From page 39 A review of the resident's NJ Exec. Order 26:4.b.1 Evaluation & Plan of Treatment dated 03/16/23, indicated that the resident had *Ex Order 26. 4B1* in his/her *Ex Order 26. 4B1* . A review of the resident's *Ex Order 26. 4B1* Discharge Summary (OTDS) dated 03/16/23, indicated that a *Ex Order 26. 4B1* wearing schedule was appropriate for the resident for *Ex Order 26. 4B1* and to prevent further *Ex Order 26. 4B1*. The OTDS recommended *Ex Order 26. 4B1* . *Ex Order 26. 4B1* . A review of the resident's Care Plan dated 04/29/19 revealed a focus area that the resident had *Ex Order 26. 4B1* . The goal of the resident's Care Plan reflected that the resident would have no injury related to *Ex Order 26. 4B1* during the review period. The interventions in the resident's Care Plan included that the resident was dependent on staff for putting on and off the *Ex Order 26. 4B1*. The Care Plan reflected that the resident had a *Ex Order 26. 4B1* . The Care Plan intervention instructed staff to put on *Ex Order 26. 4B1* in the AM and remove prior to PM care. On 05/19/23 at 11:03 AM, the surveyor interviewed the resident's Certified Nursing Aide (CNA) who stated that the resident could NJ Exec. Order 26:4.b.1 The CNA told the surveyor that either he or the nurse put the *Ex Order 26. 4B1* on the resident's *Ex Order 26. 4B1* because the	F 688		

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F 688	Continued From page 40	F 688		

resident had Ex Order 26. 4B1. The CNA further stated that the resident did not remove the Ex Order 26. 4B1 on his/her own. The surveyor asked the CNA what Ex Order 26. 4B1 the resident wore? The CNA explained that the resident wore a Ex Order 26. 4 on his/her Ex Order 26. 4B1 .

On 05/19/23 at 11:07 AM, the surveyor entered Resident #68's room with the CNA. The CNA observed that the resident did not have a hand Ex Order 26. 4 on his/her Ex Order 26. 4B1 and told the surveyor that he thought that he had seen one on the resident's Ex Order 26. 4B1 before but couldn't find one to put on the resident. The CNA then opened the top drawer of the resident's nightstand in front of the surveyor and stated, "I couldn't find it." The surveyor did not observe the Ex Order 26. 4B1 in the drawer.

On 05/19/23 at 11:11 AM, the surveyor interviewed the resident's Licensed Practical Nurse (LPN) who stated that she worked with a staffing agency, and it was her first time caring for the resident. The LPN further stated that she received report that the resident was Ex Order 26. 4B1 and received a Ex Order 26. 4B1 for their nutrition. The surveyor asked the LPN if she received information on report regarding Ex Order 26. 4 . The LPN stated, No. To be honest I did not know if the resident had Ex Order 26. 4B1 ."

On 05/19/23 at 11:22 AM, the surveyor entered the resident's room with the LPN who looked through the resident's drawers in the presence of the surveyor and was unable to find the Ex Order 26. 4 for the resident's Ex Order 26. 4B1 . The LPN stated, "Yeah, I don't see no Ex Order 26. 4B1 ."

On 05/19/23 at 11:42 AM, the surveyor

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F 688	Continued From page 41 interviewed the Rehab Director (RD) who stated that he was familiar with the resident because he made weekly rounds throughout the facility to make sure the resident's that had POs for Ex Order 26. 4B1 were wearing them. The RD further stated that the resident was picked up for Ex Order 26. 4B1 services on 03/16/23 for Ex Order 26. 4B1 and the evaluation revealed that the resident was to wear a Ex Order 26. 4B1 to prevent against further Ex Order 26. 4B1. The RD told the surveyor that the resident should have been wearing the Ex Order 26. 4B1 and Ex Order 26. 4B1 as prescribed by the physician. The RD stated that the nursing department was responsible for the application of the Ex Order 26. 4B1 and if the nurses or CNAs could not find a Ex Order 26. 4B1, they could have come to him to ask for one and he could have supplied it to the resident. On 05/31/23 at 09:50 AM, the surveyor interviewed the Director of Nursing (DON) who stated that the appropriate Ex Order 26. 4B1 should have been placed on the resident per the PO to prevent further Ex Order 26. 4B1. A review of the facility's Orthotic Management Policy and Procedure dated 07/20/22, indicated, 'Ex Order 26. 4B1 management is a Ex Order 26. 4B1 procedure designed to prevent worsening Ex Order 26. 4B1 to a Ex Order 2, to increase range of motion, and/or to prevent Ex Order 2." The facility's Orthotic Management Policy and Procedure further indicated, 'Ex Order 26. 4B1 will collaborate with nursing to get an order in place once trial has completed for ongoing Ex Order 26. 4B1 Ex Order 26. 4B1 wearing schedule. At which time the may be donned [put on] and doffed [removed] by nursing staff or certified nursing	F 688		

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F 688	Continued From page 42 assistant, or other designated trained personnel. NJAC 8:39-27.1(a)	F 688		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Part A Based on observation, interview, record review, and review of pertinent facility documentation, it was determined the facility failed to ensure the appropriate *Ex Order 26. 4B1* diet for a resident who was at risk for *Ex Order 26. 4B1* [redacted]. This deficient practice was identified for 1 of 5 residents reviewed for accidents and accident prevention (Resident #22). According to the resident's medical record, Resident #22 had an individualized comprehensive care plan and physician's order for a *Ex Order 26. 4B1* due to NJ Exec. Order 26:4.b. [redacted] and a risk for *Ex Order 26. 4B1*. However, on 05/16/23 at 12:25 PM, Surveyor #1 observed a meal ticket for Resident #22 on their	F 689	Part A Element 1 R22s tray was removed from resident. A new tray was provided with pureed sauerkraut. R22 was assessed by a Registered Nurse on 5/16/2023. R22 absent of signs and symptoms of *Ex Order 26. 4B1*. Vitals are stable and will continue to monitor. *Ex Order 26. 4B1* assessed R22 on 5/16/2023 and as a precautionary measure, accepted R22 on caseload for *Ex Order 26. 4B1* [redacted]. The registered Dietitian will evaluate R22 and update the plan of care as necessary. Nursing staff education on checking tray tickets prior to serving residents tray initiated on 5/16/2023 and is ongoing. Dietary staff re-educated on tray line accuracy and checking tray tickets prior to placing tray on cart initiated on 5/16/2023 and is	6/1/23

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F 689	Continued From page 43 lunch tray which indicated pureed sauerkraut. At that time, the Surveyor #1 observed the resident eating a regular textured sauerkraut from his/her lunch tray. The sauerkraut was long and stringy in appearance. The facility staff did not verify the meal ticket with the contents on the lunch tray prior to delivering the lunch tray to Resident #22 to ensure safety and dietary accuracy to prevent Ex Order 26. 4B1. The facility's failure to ensure a resident with a history of Ex Order 26. 4B1 received the appropriate Ex Order 26. 4B1 diet posed a serious and immediate threat for an adverse outcome, including NJ Exec. Order 26:4.b and Ex Order 26. 4B1, which is likely to result in serious harm, impairment, or death. This resulted in an Immediate Jeopardy (IJ) situation that began on 05/16/23 at 12:25 PM, when Resident #22 was served the incorrect textured sauerkraut without staff verifying the accuracy of the meal ticket at the time of meal plating and service to the resident. The facility's administration was notified of the IJ on 05/16/23 at 4:29 PM. The facility submitted an acceptable written Removal Plan on 05/16/23 at 7:37 PM. The survey team verified the implementation of the Removal Plan through observation and interview during the continuation of the on-site survey on 05/17/23. This deficient practice was evidenced by the following: On 05/16/23 at 12:25 PM, Surveyor #1, who was standing approximately five feet away, observed	F 689	ongoing. Element 2 Any resident with an order for a Ex Order 26. 4B1 product is at risk for the same deficient practice. An audit was initiated of all residents with current orders for a Ex Order 26. 4B1 diet with pureed vegetable consistency and no other residents were affected. Element 3 The facility reviewed the policy and procedures for Ex Order 26. 4B1 diets. Nursing staff re-educated on the policy and procedures of Ex Order 26. 4B1 diets and checking the tray ticket to ensure the residents tray corresponds with the dietary order was initiated on 5/16/2023. Food service staff re-educated on tray line procedure, checking the tray ticket orders with the completed tray prior to placing tray on cart for delivery was initiated on 5/16/2023. Element 4 DON or Designee will observe the meal service of 10 residents per week for 60 days to ensure that the residents tray ticket food consistencies match the food being served to the residents beginning on 5/17/2023. Dietary staff will audit 5 trays daily to ensure tray accuracy prior to food leaving the kitchen for 2 weeks, then 5 trays weekly for 6 weeks to ensure accuracy initiated on 5/17/2023. The results of these audits will be reported to the QAPI committee monthly. Results of audits will be reported to the QAPI	

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F 689	Continued From page 44 Certified Nursing Assistant (CNA) #1 deliver a lunch tray to Resident #22 in the Court[redacted] dining room. The resident immediately picked up the fork from the tray and began eating the sauerkraut, which was long and stringy in appearance. The facility staff in the dining room were not observed directly supervising or assisting the resident with his/her meal. The surveyor approached Resident #22 and observed the resident's tray further consisted of a [redacted] meat, mashed potatoes, but it had regular textured sauerkraut. The surveyor reviewed the resident's meal ticket and before the resident took another bite of sauerkraut, the surveyor immediately called over CNA#1 to check the resident's meal ticket against the lunch tray. CNA #1 then verified the resident's meal ticket indicated the resident was on a *Ex Order 26. 4B1* diet and should have received "Pureed Sauerkraut (Soft & Drained) - 4 oz." When asked about the texture of the sauerkraut on the resident's tray, CNA#1 stated, "It's not pureed." The CNA then removed the lunch tray from Resident #22 and Licensed Practical Nurse (LPN)#1 took the lunch tray to the kitchen. When LPN#1 returned, she delivered a new lunch tray to Resident #22, and stated the sauerkraut on the original lunch tray was not pureed and that the resident was supposed to receive a *Ex Order 26. 4B1* [redacted] diet to prevent [redacted] According to the Admission Record (an admission summary), Resident #22 had diagnoses which included, but were not limited to, *Ex Order 26. 4B1* [redacted].	F 689	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 689 Part B Element 1 The water for residents in rooms [redacted] and [redacted] were shut off at the hot water valve immediately. As a precautionary measure, the hot water valves in rooms *Ex Order 26. 4B1* were also shut off. There were no residents in the rooms during the time of this event. The facility contacted GE Mechanical to assess the situation. It was found that the return circulator pump malfunctioned. The mechanics shut down the hot water return. Temperatures were taken throughout the facility and no other rooms/area were affected. All rooms recorded temperatures between 95-102 degrees Fahrenheit. Element 2 Temperatures were obtained from all patient care areas/rooms to ensure temperatures did not reach above 110 degrees. No other rooms were affected. Element 3 Direct care staff were educated on the policy of water temperatures, and notification of maintenance/supervisor if water temperatures are above 110 degrees F. Education started on 5/24/23. Maintenance staff will continue to monitor water temperatures daily to ensure all	

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F 689	Continued From page 45 Review of a Ex Order 26. 4B1 Discharge Summary, dated Ex Order 26. 4B1, included a diet recommendation for 'Ex Order 26. 4B1 [redacted]," and, "Swallow Strategies/Positions: To facilitate safety and efficiency, it is recommended the patient use the following strategies and/or maneuvers during oral intake:.. NJ Exec. Order 26:4.b.1 [redacted] Further review of the discharge summary included, "Supervision for NJ Exec. Order 26:4.b.1 [redacted] Review of the quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 03/22/23, revealed Resident #22 had a Brief Interview for Mental Status (BIMS) score of Ex Ord [redacted] out of 15 which indicated that the resident's cognition was Ex Order 26. 4B1 . Further review of the MDS included the resident required supervision and setup help NJ Exec. Order 26:4.b.1. It further revealed that the resident was on a Ex Order 26. 4B1 diet which required a change in texture of food or liquids. Review of the Medical Nutrition Ex Order 26. 4B1 Assessment, dated 03/24/23, included the resident had a diagnosis of Ex Order 26. 4B1 [redacted]. Further review of the nutrition assessment included a note from the Registered Dietician (RD) which indicated Resident #22, "continues on Ex Order 26. 4B1 diet with Ex Order 26. 4B1 [redacted] - tolerates Ex Order 26. 4B1 diet for history of Ex Order 26. 4B1." Review of the resident's individualized. comprehensive Care Plan included a focus of, "[Resident #22] has a nutritional problem or	F 689	mechanical systems are in proper working order. Element 4 Maintenance director/designee will monitor water temperatures in 3 rooms per unit daily to ensure water temperatures are below 110* F. The results of these audits will be reported 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.	

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

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F 689	Continued From page 46 potential nutritional problem r/t [related to] need for Ex Order 26. 4B1 diet and Ex Order 26. 4B1 ," initiated on 09/17/20, with an intervention to, "provide and serve diet as ordered: regular, Ex Order 26. 4B1, Ex Order 26. 4B1 liquids." Further review of the individualized, comprehensive Care Plan included a focus that "[Resident #22] has Ex Order 26. 4B1 ," initiated on 01/31/22, and that "Resident is at risk for Ex Order 26. 4B1 related to: Ex Order 26. 4B1," initiated 08/10/22. An intervention included to, "supervise and or provide assistance to resident during NJ Exec. Order 26:4.b.1." Review of the Physician's Order Form, dated 05/2023, included a diet order for, "Ex Order 26. 4B1 , Ex Order 26. 4B1 ," with an order date of 01/20/23. Review of the May 2023 Medication Administration Record (MAR) included the corresponding physician's diet order for "Ex Order 26. 4B1 ." During an interview with Surveyor #1 on 05/16/23 at 12:57 PM, CNA#1 stated that during meal service, the CNAs passed out the trays and were supposed to check the resident's meal ticket against the meal tray to ensure it was correct. CNA#1 further stated that the meal tickets included the residents' prescribed diet texture and that it was important that the resident received the correct diet texture to prevent choking. When asked about Resident #22's lunch tray, CNA#1 stated that Resident #22's lunch tray did not match the meal ticket and had to be sent back to the kitchen and replaced with the correct tray.	F 689		

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F 689	Continued From page 47 During an interview with Surveyor #1 on 05/16/23 at 1:01 PM, LPN#1 stated that during meal service, the nurses and CNAs passed out the trays. She further explained that the nurse was supposed to check the meal ticket against the meal tray to ensure the resident's diet matches the texture of the food on the tray. Afterwards, the CNAs checked the meal ticket against the meal tray again before serving the resident. LPN#1 also stated that it was important to ensure residents received the correct diet texture to prevent Ex Order 26. 4B1. When asked about Resident #22's lunch tray, LPN#1 stated that CNA#1 took the meal tray from the meal cart before she could check the ticket against the tray. During an interview with Surveyor #1 on 05/16/23 at 1:04 PM, the Registered Nurse/Unit Manager (RN/UM) stated that during meal service, the kitchen aides brought the meal cart to the unit and then the nurse or CNA checked the meal ticket against the meal tray before serving the resident. The RN/UM further explained that the meal ticket included the resident's allergies, prescribed diet texture, and the food items included on the tray. The RN/UM then stated that multiple checks were performed to prevent the resident from receiving the wrong diet texture and choking. When asked about Resident #22, the RN/UM stated the resident has a diagnosis of Ex Order 26. 4B1 and was on a prescribed Ex Order 26. 4B1 diet with Ex Order 26. 4B1 liquids to prevent NJ Exec. Order 26:4.B.1 During an interview with Surveyor #2 on 05/16/23 at 1:04 PM, the Registered Dietician (RD) stated that during meal service, dietary staff delivered the meal cart to the unit and then the unit staff passed out the trays to the residents. The RD	F 689		

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further explained that the UM would check the meal ticket against the meal tray to ensure that the resident's name, allergies, and [redacted] food matched appropriately. The RD also stated that it was important that residents received the correct diet texture to prevent [redacted]

During an interview with Surveyor #3 on 05/16/23 at 1:06 PM, the [redacted] (SLP) explained the different types of diet textures included [redacted] The SLP further stated that the importance of serving the correct altered consistency diet was to prevent [redacted] or [redacted]. When asked about the resident meal service, the SLP stated it was the dietary staff's responsibility to ensure they were preparing the correct consistency diet and the nursing staff's responsibility to ensure they were serving the correct consistency diets by verifying the meal tickets against the meal trays.

During an interview with Surveyor #4 on 05/16/23 at 1:14 PM, the Dietary Aide (DA) stated that during meal service, the dietary staff were supposed to read the meal ticket before putting food on the meal tray to ensure it was the correct diet texture. The DA further stated that it was important to make sure the diet texture was accurate to prevent residents from [redacted]

During an interview with Surveyor #4 on 05/16/23 at 1:19 PM, the Cook stated that during meal plating in the kitchen the first dietary staff told the Cook the resident's diet based on the meal ticket. Then a second dietary staff would check the meal tray to ensure it matched the meal ticket; a third

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F 689	Continued From page 49 dietary staff would follow up with a triple check. The Cook further stated that if a resident was on a *Ex Order 26. 4B1* diet due to NJ Exec. Order 26:4.b.1 concerns, the resident was at risk for NJ Exec. Order 26:4.b.1 The Cook added that any residents on a Ex Order 26. 4B1 diet would be required to have pureed sauerkraut to prevent NJ Exec. Order 26:4.b.1 During an interview with Surveyor #5 on 05/16/23 at 1:31 PM, the Certified Dietary Manager/Certified Food Protection Professional (CDM/CFPP) stated that it was important that the dietary staff ensure the meal tray matched the meal ticket to prevent a resident with a NJ Exec. Order 26:4.b.1 from NJ Exec. Order 26:4.b.1. During an interview with Surveyor #4 on 05/16/23 at 1:33 PM, the Food Service Director (FSD) stated that during meal plating, the DA would call out the food listed on the resident's meal ticket and that the meal ticket included the resident's name, type of diet, texture/consistency of the food and drinks, and the resident's allergies. The FSD further explained that after the DA called out the food, the meal tray would go to a second dietary staff who would add dessert to the tray, then the tray would go to the Cook who plated the food according to the meal ticket. The FSD stated that lastly the tray would go to another dietary staff who added the juice items before the tray was placed on the meal cart. The FSD also stated that it was important to provide the appropriate food textures to prevent NJ Exec. Order 26:4.b.1 and Ex Order 26. 4B1. During an interview with Surveyor #4 on 05/16/23 at 1:42 PM, the Assistant Food Service Director (AFSD) stated that during meal service, there was a DA that would review the resident's meal ticket on the tray line and call out the food items	F 689		

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listed. The ASFD further explained that the meal tray would go down the line to a second dietary staff who would put desserts and lids on the tray, then the tray would go to the Cook who would put the food onto the tray. The AFSD added that lastly the tray would go to another dietary staff who would put the beverages on the tray and review the meal ticket to ensure it matched the tray before being placed on the meal cart. The AFSD stated that nurses and CNAs were also responsible for checking the meal ticket against the meal tray to ensure it matched, because if the resident was on a *Ex Order 26. 4B1* diet, the resident could [NJ Exec. Order 26] if they received the incorrect food texture.

During a follow-up interview with the survey team on 05/16/23 at 2:43 PM, the SLP stated that a resident on a *Ex Order 26. 4B1* diet would require [Ex Order 26. 4B1] sides if it were specified on the meal ticket. The SLP further stated that because sauerkraut was "more of a raw vegetable," it would need to be [Ex Order 26. 4B1] due to the tougher, fibrous-nature of the skin of the vegetable for someone on a *Ex Order 26. 4B1* diet to prevent [NJ Exec. Order 26:4.b.i]

During an interview with Surveyor #1 and #5 on 05/16/23 at 2:54 PM, the Director of Nursing (DON) stated the dietary staff checked the meal trays prior to leaving the kitchen, then the nurse on the unit checked the meal ticket against the meal tray for accuracy, and lastly, the CNA serveed the meal trays to the residents. The DON further stated that it was important to make sure the resident received the correct diet texture to prevent [NJ Exec. Order 26:4.b.i]

During an interview with Surveyor #1 and #5 on

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F 689	Continued From page 51 05/16/23 at 2:59 PM, the Executive Director (ED) stated the dietary staff delivered the meal cart to the unit, then the nurse on the unit checked to make sure the meal tray matched the meal ticket, and lastly, the CNA served the meal trays to the residents. The ED further stated that the dietary tray line is the first line of defense, and the nursing staff are the second line of defense to ensure the meal trays are accurate to prevent any "safety risks." Resident #22 did not have any incidents of [NJ Exec. Order 26:4.b.1] during the 05/16/23 lunch observation, and review of the resident's medical record indicated the resident did not have any previous incidents of [NJ Exec. Order 26:4.b.1] in the past. On 05/16/23 at 4:29 PM, the facility's administration was notified that the facility's failure to ensure a resident with a history of [Ex Order 26. 4B1] received the appropriate [Ex Order 26. 4B1] diet posed a serious and immediate threat for a serious adverse outcome, including [NJ Exec. Order 26:4.b] and [Ex Order 26. 4B1], which are likely to result in serious harm, impairment, or even death. An acceptable Removal Plan was received on 05/16/23 at 7:37 PM and verified by the survey team though observation and interview during the continuation of the on-site survey on 05/17/23. Review of the facility's Nutritional Services policy, last reviewed 02/01/23, included, "Remove one tray at a time from the food cart; check tray card for the resident's name and room number; type of diet, consistency, food preferences; check for utensils and appropriate condiments." Review of the facility's National [Ex Order 26. 4B1] Diet	F 689		

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F 689	Continued From page 52 (NDD) document, undated, included a section titled "Food Textures for NDD Level [redacted]: Ex Order 26. 4B1 [redacted]," which indicated to avoid, "broccoli, cabbage, brussels sprouts, asparagus, or other fibrous, non-tender or rubbery cooked vegetables." Part B Based on observation, interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to ensure water temperatures were within an appropriate, safe range to prevent scalding and burns to residents' skin. This deficient practice was identified for 3 of 3 residents reviewed (Resident #16, #62, and #128) on 1 of 4 nursing units (the Ex Order 26. 4B1 unit) when resident room water temperatures when tested ranged from 142 to 152 degrees Fareinheit, which was outside the acceptable water temperature ranges and not in accordance with the facility's water temperature policy. Interviews with the Certified Nursing Aides (CNA)s, Licensed Practical Nurses (LPN) and a housekeeper on the Ex Order 26. 4B1 unit indicated that at times there were temperature inconsistencies with the water on the unit. CNA#2 informed the surveyor that Resident #19, #62, and #128 were all able to independently operate the sink in their bathrooms. The facility's failure to maintain appropriate water temperatures placed residents on the Ex Order 26. 4B1 Unit at a likelihood of scalding or skin burns which	F 689		

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could result in serious harm, impairment, or death. Vulnerable residents are more prone to burns due to decreased skin thickness, decreased skin sensitivity, peripheral neuropathy (loss of sensation in arms, hands, and lower limbs), reduced reaction time, decreased cognition, decreased mobility, and decreased communication.

This deficient practice resulted in an Immediate Jeopardy (IJ) situation that began on 05/24/23 at 10:18 AM when the Life Safety Code (LSC) surveyor identified the elevated water temperatures on the [redacted] unit.

The facility's administration was notified of the IJ on 05/24/23 at 3:54 PM. The facility submitted an acceptable written Removal Plan on 05/25/23 at 12:26 PM. The survey team verified the implementation of the Removal Plan during the continuation of the on-site survey on 05/25/23.

The findings were as follows:

A review of the facility's undated Water Temperature Policy inclucded that, "Tap water in the facility shall be kept within a temperature range to prevent scalding of residents." It further included that "water heaters that service resident rooms, bathrooms, common areas, and tub/shower areas shall be set to temperatures of no more than 110 degrees Fahrenheit, or the maximum allowable temperature per state regulation."

On 05/24/23 at 9:23 AM, the Life Safety Code (LSC) surveyor toured the [redacted] unit in the presence of the Maintenance Director (MD).

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F 689	Continued From page 54 At 10:18 AM, the LSC surveyor in the presence of the MD tested the water temperature in resident room [NJ Exec. Ord] on the [Ex Order 26. 4B1] unit. The water temperature read 152 degrees Fahrenheit in the resident's bathroom. At 10:20 AM, the LSC surveyor in the presence of the MD went to another resident room, and tested the water temperature. The surveyor observed that in the resident bathroom of room [Ex Order], the water temperature tested 142 degrees Fahrenheit. At 10:25 AM, the Corporate Vice President of Environmental Services (CVP/ES) joined the tour with the LSC surveyor and MD on the [Ex Order 26. 4B1] unit and observed in resident room [Ex Order] a water temperature of 149 degrees Fahrenheit. This indicated a seven (7) degree temperature increase. The LSC surveyor informed the MD to immediately turn off the domestic hot water supply to the five (5) bathroom sinks located on that hall on the [Ex Order 26. 4B1] unit. At 10:44 AM, Surveyor #4 interviewed CNA#3 who stated that she gave a resident a shower during her shift that day and the water in the shower room was "lukewarm." CNA#3 told Surveyor #4 that sometimes she would turn the water on in the resident's bathrooms on the [Ex Order 26. 4B1] unit and the water would be burning hot. CNA#3 further stated that this didn't happen too often and the last time she recalled it happening was about a week ago. Surveyor #4 asked CNA#3 if she told anyone that the water coming from the faucet was burning hot and she stated that she thought she might have told an agency nurse.	F 689		

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F 689	Continued From page 55 At 10:49 AM, Surveyor #4 interviewed LPN#2 who worked the high side rooms on the [redacted] unit. LPN#2 informed the surveyor that sometimes when she washed her hands on the [redacted] unit there were temperature inconsistencies and at times, water would come out too hot. LPN#2 stated the water had never burned her skin. At 10:52 AM, Surveyor #4 interviewed LPN#3 who worked the low side rooms on the [redacted] unit. Surveyor #4 asked LPN#3 about the hot water temperatures this morning LPN#3 stated that she did not identify that the water in the resident's rooms were hot that day and no residents had voiced concerns regarding the water temperature. LPN#3 told the surveyor that when she washed her hands, she preferred the water to be very hot. At 11:03 AM, Surveyor #4 interviewed the Housekeeper working on the low side of the [redacted] unit (rooms [redacted] and [redacted]), who stated, she noticed that the water temperatures were hot that morning. The Housekeeper further stated that sometimes she would turn on the water, and it would be hot, and other times she would turn on the water, and it would be cold. At 11:07 AM, Surveyor #4 interviewed the Licensed Practical Nurse/Unit Manger (LPN/UM) for the [redacted] unit who stated that the shower room had a thermometer by the shower head, so the water temperature was monitored to make sure it was not hot while giving the residents a shower. The LPN/UM further stated that there were no residents or staff that complained of hot water that day.	F 689		

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F 689	Continued From page 56 At 1:39 PM, the surveyor interviewed the MD who stated that the thermometers used during the tour with the LSC surveyor were functional and were used daily to monitor temperatures throughout the building. The MD further stated that when he was with the LSC surveyor, his calibrated thermometer temperatures in rooms [redacted] and [redacted] were reading elevated temperatures within two to three degrees of the LSC surveyors thermometer recording. The MD stated that he assumed room [redacted] through [redacted] were high temperatures so he shut off the hot water supply to the sinks in those five rooms. At 3:00 PM, Surveyor #4 in the presence of the LPN/UM observed Resident #19 lying in bed and smiling. The LPN/UM asked the resident if he/she could turn the water on in the bathroom sink independently. Surveyor #4 and the LPN/UM observed Resident #19 ambulate (walk) to the bathroom and turn the water on to the sink independently. At 3:03 PM, Surveyor #4 observed Resident #62 sitting peacefully in a chair on the [redacted] unit looking out of the window. The LPN/UM asked the resident if he/she could turn the water on in their bathroom. The resident shook his/her head up and down indicating, "yes." The LPN/UM then asked the resident if he/she could return demonstrate, and Resident #62 shook his/her head from side to side indicating, "no." At 3:06 PM, Surveyor #4 observed Resident #128 seated in the day room on the [redacted] unit with his/her head resting on their hand. The resident exhibited nonverbal cues that they did not want to be disturbed. At that time, the LPN/UM stated that	F 689		

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the resident would probably not cooperate and turn on the water, even if she asked the resident to do it, so the surveyor did not interfere with the resident's non-verbal cues for privacy.

At 03:07 PM, Surveyor #4 conducted a follow up interview with CNA#2 who stated that Resident #19, Resident #62, and Resident #128 could all turn the water on in their bathrooms independently.

The surveyor reviewed the medical record for Resident #19.

A review of the resident's Admission Record reflected that the resident had resided at the facility for NJ Exec. Order 26:4.b.1 and had diagnoses which included but were not limited to Ex Order 26. 4B1 [redacted].

A review of the resident's quarterly MDS dated 04/13/23, indicated that the resident's cognitive skills for decision making were *Ex Order 26. 4B1* .

A review of Resident #19's Care Plan revised 01/30/19, reflected a focus area that the resident had potential to NJ Exec. Order 26:4.b.1 related to [redacted]. The goal of the resident's Care Plan was the resident's would remain NJ Exec. Order 26:4.b.1. Interventions included to identify and document potential causative factors and eliminate them so the resident's NJ Exec. Order 26:4.b.1 .

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F 689	Continued From page 58 The surveyor reviewed the medical record for Resident #62. A review of the residents Admission Record revealed that the resident had resided at the facility for NJ Exec. Order 26:4.b.1 and had diagnoses which included but were not limited to Ex Order 26. 4B1 [redacted]. A review of Resident #62's quarterly MDS dated 03/16/23, reflected that the resident had a BIMS score of [redacted] out of 15 which indicated the resident had Ex Order 26. 4B1 [redacted]. A review of the resident's Care Plan dated 04/05/22, indicated a focus area that the resident was at risk for NJ Exec. Order 26:4.b.1 to NJ Exec. Order 26:4.b.1 related to Ex Order 26. 4B1. The goal of the residents Care Plan was that the resident's [redacted] would be NJ Exec. Order 26:4.b.1 through the next review date. The interventions included to use caution during transfers and bed mobility to prevent striking arms, legs, and hands. A further review of Resident #62's Care Plan reflected a focus area dated 04/05/22, that the resident had Ex Order 26. 4B1 [redacted] or impaired thought process related to Ex Order 26. 4B1 and difficulty making decisions. The goal of the residents Care Plan indicated that the resident would be able to communicate basic needs and have their needs anticipated through the review date. Interventions in the residents Care Plan included to cue, reorient, and supervise as	F 689		

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F 689	Continued From page 59 needed. The surveyor reviewed the medical record for Resident #128. A review of the resident's Admission Record reveled that the resident had resided at the facility for a [redacted] and had diagnoses which included but were not limited to [redacted]. A review of the resident's admission MDS dated 04/03/22, indicated that the resident had a BIMS score of [redacted] out of 15 which indicated that the resident had [redacted]. A review of the resident's Care Plan dated 04/04/23, revealed a focus area that the resident was having an [redacted] to the facility as evidenced by verbal aggression and throwing chairs. The goal of the resident's Care Plan was the resident would express satisfaction with placement in the nursing facility within the next 90 days. Interventions in the residents Care Plan included to orient the resident to routines and provided one-to-one visits. A review of the Daily Resident Rooms Temperature and Logs from 05/12/23 through 05/23/23 indicated that random checks on the [redacted] Unit were within normal range. A further review of the Daily Resident Rooms Temperature and Logs revealed the following: -On 05/12/23, room [redacted] had a water temperature of 99.8 degrees Fahrenheit, room [redacted] had a water temperature of 100.9 degrees Fahrenheit,	F 689		

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F 689	Continued From page 60 and room [redacted] had a water temperature of 90.6 degrees Fahrenheit. -On 05/13/23, room [redacted] had a water temperature of 99.6 degrees Fahrenheit, room [redacted] had a water temperature of 98.7 degrees Fahrenheit, and room [redacted] had a water temperature of 99.5 degrees Fahrenheit. -On 05/14/23, room [redacted] had a water temperature of 99.1 degrees Fahrenheit, room [redacted] had a water temperature of 98.8 degrees Fahrenheit, and room [redacted] had a water temperature of 99.5 degrees Fahrenheit. -On 05/15/23, room [redacted] had a water temperature of 102.3 degrees Fahrenheit, room [redacted] had a water temperature of 101.6 degrees Fahrenheit, and room [redacted] had a water temperature of 100.4 degrees Fahrenheit. -On 05/16/23, room [redacted] had a water temperature of 100.3 degrees Fahrenheit, room [redacted] had a water temperature of 101.4 degrees Fahrenheit, and room [redacted] had a water temperature of 100.2 degrees Fahrenheit. -On 05/17/23, room [redacted] had a water temperature of 103.8 degrees Fahrenheit, room [redacted] had a water temperature of 102.7 degrees Fahrenheit, and room [redacted] had a water temperature of 101.8 degrees Fahrenheit. -On 05/18/23, room [redacted] had a water temperature of 103.2 degrees Fahrenheit, room [redacted] had a water temperature of 100.6 degrees Fahrenheit, and room [redacted] had a water temperature of 101.3 degrees Fahrenheit.	F 689		

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F 689	Continued From page 61 -On 05/19/23, room [Ex Order] had a water temperature of 102.6 degrees Fahrenheit, room [Ex Order] had a water temperature of 103.5 degrees Fahrenheit, and room [Ex Order] had a water temperature of 103.8 degrees Fahrenheit. -On 05/20/23, room [Ex Order] had a water temperature of 100.3 degrees Fahrenheit, room [Ex Order] had a water temperature of 100.1 degrees Fahrenheit, and room [Ex Order] had a water temperature of 99.8 degrees Fahrenheit. -On 05/21/23, room [Ex Order] had a water temperature of 99.8 degrees Fahrenheit, room [Ex Order] had a water temperature of 98.7 degrees Fahrenheit, and room [Ex Order] had a water temperature of 100.1 degrees Fahrenheit. -On 05/22/23, room [Ex Order] had a water temperature of 98.9 degrees Fahrenheit, room [Ex Order] had a water temperature of 96.2 degrees Fahrenheit, and room [Ex Order] had a water temperature of 95.8 degrees Fahrenheit. -On 05/23/23, room [Ex Order] had a water temperature of 100.3 degrees Fahrenheit, room [Ex Order] had a water temperature of 100.2 degrees Fahrenheit, and room [Ex Order] had a water temperature of 100.1 degrees Fahrenheit. According to the CMS's Table 1. Time and Temperature Relationship to Serious Burns, a water temperature of 140 degrees Fahrenheit only requires 5 seconds of contact before a third degree burn occurs; a temperature of 148 degrees Fahrenheit requires only 2 seconds of contact before a third degree burn occurs, a water temperature of 155 degrees Fahrenheit only requires 1 second of contact before a third	F 689		

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F 689	Continued From page 62 degree burn. NJAC 8:39-17.4(a)(2);27.1(a);31.7(h)	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to maintain [NJ Exec. Order 26:4.b.1] equipment in a clean and sanitary condition for 1 of 3 residents, (Resident #83) reviewed for [Ex Order 26. 4B1] care. This deficient practice was evidenced by the following: On 05/16/23 at 11:43 AM, in Resident #83's room, the surveyor observed a [Ex Order 26. 4B1] [redacted] resting on his/her side table connected to [Ex Order 26. 4B] and a mask with a connected medication (med) cup. The [Ex Order 26. 4B] and the mask/med cup were inside of a clear plastic bag and the [Ex Order 26. 4B] and the bag were both dated 05/10/23. There was white debris observed on the inside of the mask. The resident was not in his/her room.	F 695	Element 1: Resident # 83 mask was changed. The resident was not affected by the deficient practice. Element 2: Any resident can be affected by this deficient practice. All residents with [Ex Order 26. 4B1] masks were audited to ensure the masks were clean. No other negative outcomes were identified. Element 3: The ADON in-serviced the nursing staff the facilities Policy and Procedure of [Ex Order 26. 4B1] which includes how to clean the mask. This in-service was conducted on 6/2/23. Element 4: The ADON/Designee will audit weekly x 4	6/14/23

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F 695	Continued From page 63 On 05/16/23 at 12:34 PM, the resident was observed fully dressed and seated in a chair in the dining room. On 05/17/23 at 12:11 PM, in Resident #83's room, the surveyor observed a [redacted] resting on his/her side table connected to [redacted] and a mask with a connected med cup. The [redacted] and the mask/med cup were inside of a clear plastic bag and the [redacted] and the bag were dated 05/10/23. There was white debris observed on the inside of the mask. The resident was not in his room. According to the Admission Record, Resident #83 was admitted to the facility in [redacted] with diagnoses which included, but were not limited to, [redacted] Review of Resident #83's quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated 05/04/23, revealed the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15 which indicated that the resident's cognition was [redacted]. Review of Resident #83's Physician's Orders revealed a physicians's order dated 04/25/23, for [redacted] (every) 8 hours for [redacted]. Review of Resident #83's Routine [redacted] Medication Administration Record (MAR), dated	F 695	weeks to ensure residents ordered [redacted] are clean then monthly x 1 month. These results will be reviewed at the facilities QA meeting monthly. The QA committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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F 695	Continued From page 64 05/2023, reflected the above physician's order and was documented as follows: The 06:00 AM dose was marked refused on 05/10/23, 05/11/23, 05/12/23, 05/13/23, 05/14/23, 05/15/23, 05/16/23, and 05/17/23. The 02:00 PM dose was marked as administered on 05/10/23, 05/11/23, 05/12/23, 05/13/23, 05/14/23, 05/15/23, 05/16/23, and 05/17/23. The 10:00 PM dose was marked as administered on 05/10/23, 05/12/23, 05/13/23, 05/14/23, 05/15/23, 05/16/23, 05/17/23 and was marked as refused on 05/11/23. On 05/24/23 at 09:06 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) caring for Resident #83 who stated that the nurse administered the Ex Order 26. 4B1 treatments to the residents. The LPN stated that after administering the medication that the mask and the med cup were washed with warm water and left to air dry then were placed into a plastic bag which contained the resident's name and date. The LPN was shown the surveyor's photographs of Resident #83's Ex Order 26. 4B1 findings from 05/16/23 and 05/17/23. The LPN acknowledged the debris in the Ex Order 26. 4B1 mask and stated that the debris should not have been there. The LPN stated it was important that the Ex Order 26. 4B1 mask/med cup should have been cleansed with warm water prior to administering the Ex Order 26. 4B1 treatment because debris and bacteria could have accumulated. On 05/24/23 at 09:32 AM, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM) who stated that the nurse's responsibility included administering Ex Order 26. 4B1 treatments and caring for the Ex Order 26. 4B1 equipment. The RN/UM was shown the	F 695		

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F 695	Continued From page 65 surveyor's photographs of Resident #83's Ex Order 26. 4B1 findings from 05/16/23 and 05/17/23. The RN/UM acknowledged the debris in the Ex Order 26. 4B1 mask and stated that the debris should not have been there. The RN/UM stated that the Ex Order 26. 4B1 equipment should have been cleansed after each use with soap and water, rinsed well, dried and stored in a plastic bag and that the debris was a risk for an infection. On 05/24/23 at 09:43 AM, the surveyor interviewed the Director of Nursing (DON) who stated that the nurse's responsibility included the care and cleaning of a resident's Ex Order 26. 4B1 treatments. The DON was shown the surveyor's photographs of Resident #83's Ex Order 26. 4B1 findings from 05/16/23 and 05/17/23. The DON acknowledged the debris in the Ex Order 26. 4B1 mask and stated that it was residue from the Ex Order 26. 4B1 treatment and that it should not have been there. The DON stated that the nurse should have washed the mask with soap and water, dried it, then stored it in a plastic bag and that a dirty mask was a risk for an infection. On 05/24/23 at 10:11 AM, the surveyor interviewed the Infection Preventionist (IP) who stated that the nurse's responsibility included the care of the Ex Order 26. 4B1. The IP was shown the surveyor's photographs of Resident #83's Ex Order 26. 4B1 findings from 05/16/23 and 05/17/23. The IP acknowledged the debris in the Ex Order 26. 4B1 mask and stated that if the mask was rinsed properly that the debris would not have been there. The IP stated that after administering the medication that the nurse should have cleansed the mask and allowed it to air dry then placed it into a plastic bag for infection control.	F 695		

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F 695	Continued From page 66 On 05/25/23 at 12:37 PM, the surveyors met in the conference room with the Executive Director, the DON, the Assistant Director of Nursing, and the Regional Nurse who were informed of the debris observed on Resident #83's Ex Order 26. 4B1 mask. A review of the facility policy, Ex Order 26. 4B1 with a revision date of July 2022, revealed Procedure: 16. Following medication administration, rinse equipment with hot water and place on paper towel to air dry. Cleaning Ex Order 26. 4B1: 3. Rinse under hot tap water to remove any residual after each use.	F 695		
F 755 SS=D	NJAC 8:39 - 27.1 (a) Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-	F 755		6/14/23

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F 755	Continued From page 67 §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility documentation, it was determined that the facility failed to: a.) administer the correct physician ordered form of *Ex Order 26. 4B1* and b.) ensure that an *Ex Order 26. 4B1* remained intact for 1 of 5 residents, (Resident #30) reviewed during medication administration. This deficient practice was evidenced by the following: On 05/22/23 at 9:14 AM, the surveyor observed the Licensed Practical Nurse (LPN) prepare medications for Resident #30. The LPN dispensed nine medications which included one tablet of *Ex Order 26. 4B1* 81 milligrams (mg). Afterwards, the LPN crushed the nine medications and mixed them in pudding. When the LPN entered the resident's room to administer the medications, Resident #30 refused to take the medications. The LPN then returned to the medication cart and reviewed the medication orders with the surveyor.	F 755	Element 1: Resident # 30 was not affected by this deficient practice. Element 2: Any resident can be affected by the deficient practice. No other negative outcomes were identified. Element 3: The ADON provided an educational consultation to the nurse involved in the deficient practice on 5/22/2023 The ADON educated the Licensed Professionals on the facilities Medication Administration Policy. Element 4. The ADON/Designee will conduct med pass audits on each nurse. These audits will be conducted randomly over the next 3 months. All findings of concern will be immediately addressed and reported to the QAPI committee monthly for further review.	

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Review of the resident's Medication Administration Record (MAR), dated 05/2023, revealed the resident had a physician's order for *Ex Order 26. 4B1* [redacted] 81 mg one tablet by mouth twice daily.

On 05/22/23 at 9:20 AM, the surveyor interviewed the LPN who stated that she dispensed [redacted] instead of [redacted] chewable and that [redacted] medications should not be crushed. The LPN further stated that she should have re-read the physician's order and compared it to the medication bottle to prevent a medication error.

On 05/22/23 at 9:38 AM, the surveyor interviewed the LPN/Charge Nurse (LPN/CN) who stated that nurses should check the physician's order against the medication container three times while preparing medications. The LPN/CN further explained that the first check was done when the nurse took the medication container out of the medication cart, the second check was done when the nurse dispensed the medication, and the third check was done when the nurse returned the medication container back into the medication cart. The LPN/CN also stated that medications labeled [redacted] should not be crushed.

On 05/22/23 at 12:34 PM, the surveyor interviewed the Director of Nursing (DON) who stated that the nurse should have checked the medication container against the physician's order in the MAR to ensure it was the correct medication. The DON further stated that certain medications could not be crushed "due to the way it is absorbed in the body," and that the LPN should not have crushed the [redacted] medication.

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F 755	Continued From page 69 Review of the facility's Medication Administration policy, dated 04/2018, included, "Confirm that the medication name and dose are correct," and "Prior to Medication Administration: Verify each medication preparation that the medication is the RIGHT DRUG, at the RIGHT DOSE, the RIGHT ROUTE, at the RIGHT RATE, at the RIGHT TIME, for the RIGHT CUSTOMER." Further review of the policy included, "Medications are to be crushed in accordance with pharmacy guidelines and/or facility policy."	F 755		
F 761 SS=D	NJAC 8:39 - 29.2(d) Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to	F 761		6/14/23

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F 761	Continued From page 70 abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of other facility documentation, it was determined that the facility failed to properly secure medication within the medication cart for 1 of 2 nurses observed during medication administration. This deficient practice was evidenced by the following: On 05/22/23 at 8:22 AM, the surveyor observed the Registered Nurse (RN) prepare medications for Resident #47. Afterwards, the RN turned her back to the medication cart and entered the resident's room. The RN did not lock the medication cart prior to entering the resident's room and left the medication cart unattended. On 05/22/23 at 8:25 AM, the surveyor observed the RN prepare medications for Resident #57. Afterwards, the RN turned her back to the medication cart and entered the resident's room. The RN did not lock the medication cart prior to entering the resident's room and left the medication cart unattended. During an interview with the surveyor on 05/22/23 at 8:35 AM, the RN stated that she could have left the medication cart unlocked if she pulled the cart close to the resident's room and was able to see if anyone was approaching the cart. During an interview with the surveyor on 05/22/23	F 761	Element 1: Resident # 47 and resident 57 was not affected by this deficient practice. The nurse in question was educated immediately on F761 and the facility policy on medication administration. Element 2: Any resident had the potential to be affected by this deficient practice. No other negative outcomes were identified. Element 3: The ADON provided an educational consultation to the nurse involved in the deficient practice. ON 5/22/23 The ADON educated the Licensed Professionals on the facilities protocol of locking the med cart when not in eyes view. Element: 4 The ADON/Designee will conduct med pass audits on each nurse. These audits will be conducted randomly over the next 3 months. All findings of concern will be immediately addressed and reported to the QAPI committee monthly for further review.	

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F 761	Continued From page 71 at 12:34 PM, the Director of Nursing (DON) stated the nurse that administered medications should have secured the medication cart "if it is not in eye's view." The DON further stated that the medication cart should have been locked if the nurse turned his/her back to the cart. Review of the facility's Medication Administration policy, dated 04/2018, included, "Medication carts are always locked when out of sight or unattended."	F 761		
F 812 SS=D	NJAC 8:39-29.4(h) 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, interviews, and review of	F 812	Element 1	6/14/23

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F 812	Continued From page 72 facility documentation it was determined that the facility failed to: a.) ensure that dry spices were stored in closed/sealed containers and b.) maintain a can opener in a manner to prevent microbial growth and cross contamination. This deficient practice was observed and evidenced by the following: 1.) On 05/16/23 at 10:35 AM, the surveyor inspected the dry storage area and observed on the top spice shelf, a 10.5 ounce (oz) container of garlic powder uncovered without a lid, and a 16 oz container of cinnamon uncovered without a lid. The spices were not being used at the time of the observation. The Dietary Director (DD) was present and was interviewed at the time of the observation and she stated that the spice containers should have had lids on them and should have remained closed when not in use. The DD threw the garlic powder and the cinnamon in the trash in the presence of the surveyor. 2.) On 05/16/23 at 10:40 AM, the surveyor inspected a can opener that was attached to the prep table. The can opener had thick brown dried residue on the insertion point that was inserted into cans. The DD was present and interviewed at that time. The DD stated that the can opener was cleaned daily and asked the food service aid if they had cleaned the can opener that morning. The food service aid stated that she had cleaned the can opener that morning, however the can opener was observed with thick brown dried residue. The DD director stated that it must have not washed off good enough and that they would re-wash the can opener.	F 812	All spices were checked to ensure that spice container was closed/sealed on 5/16/2023. The can opener was cleaned, and a new can opener blade was ordered on 5/20/2023. Element 2 An audit was completed on 5/17/2023 to ensure that all spice containers were closed/sealed. No other spices were affected. On 5/20/2023 an assessment was completed on the can opener blade, and a galvanized substance could not be removed, so a new blade was ordered. Element 3 Dietary staff began education on 5/16/23 related to spices being closed/sealed when not in use and can opener to be washed thoroughly after each use. Element 4 Dietary Manager/designee will audit spices weekly to ensure that all spices are closed/sealed when not in use for 8 weeks. Dietary Manager/designee will audit can opener weekly for 8 weeks to ensure the blade is clean and free of debris. 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.	

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F 812	Continued From page 73 On 05/31/23 at 10:17 AM, in the presence of the survey team, the Executive Director (ED) stated that he inspected the can opener, and it appeared the substance on the can opener was, "enamelized" and couldn't seem to get clean even with scraping. He stated that he could not tell what the substance was and that the can opener needed to be replaced. The surveyor reviewed the facility policy, "Labeling and Dating System Protocol," dated 05/23, which indicated that all food items must be properly stored, dated and covered at all times. The surveyor reviewed the facility policy, "Food Service Can Opener Cleaning Policy," dated 03/2023, which indicated that all can openers are to be cleaned and sanitized at beginning of every shift and at the end of every shift as well as "as needed."	F 812		
F 880 SS=D	NJAC 8:39-17.2(g) Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880		6/14/23

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F 880	Continued From page 74 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F 880		

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F 880	Continued From page 75 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to follow appropriate hand hygiene practices: a.) during a NJ Exec. Order 26:4.b.1 treatment performed on 1 of 1 resident, (Resident #71) reviewed for NJ Exec. Order 26:4.b.1 and b.) when doffing (removing) gloves after providing care to 1 of 1 resident, (Resident #83). This deficient practice was evidenced by the following: 1.) According to the Admission Record, Resident #71 had diagnoses which included, but were not limited to, *Ex Order 26. 4B1* . Review of the resident's Treatment Administration Record, dated 05/2023, revealed a Ex Order 26. 4B1 care order for the resident's *Ex Order 26. 4B1*. On 05/24/23 at 09:05 AM, the surveyor observed the Licensed Practical Nurse (LPN) #1 perform	F 880	Element 1 LPN number one who was caring for R71, and C.N.A caring for R83 were provided with an educational consultation on proper handwashing technique and placed in their employee file. R71 and R83 were not affected by this practice. Element 2 All residents could be affected by this practice. In the interest of precaution, the facility conducted random hand hygiene audits which started on 5/20/2023 to ensure compliance. Element 3 On 5/20/2023 hand hygiene re-education was initiated for staff. Element 4 The Infection Preventionist/designee will conduct random hand hygiene observation audits beginning on 5/20/2023 weekly for 8 weeks. The results of these audits will be reported to the	

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F 880	Continued From page 76 Ex Order 26. 4B1 care on Resident #71. Throughout the procedure, LPN #1 washed her hands a total of three times. During the first handwashing observation, which occurred prior to starting the Ex Order 26. 4B1 care treatment, LPN #1 lathered her hands with soap and rubbed them together for 16 seconds before rinsing them with water. During the second handwashing observation, which occurred after removing the old Ex Order 26. 4B1, LPN #1 lathered her hands with soap and rubbed them together for 13 seconds before rinsing her hands with water. During the third handwashing observation, which occurred after completing the Ex Order 26. 4B1 care treatment, LPN#1 lathered her hands with soap and rubbed them together for 16 seconds before rinsing with water. On 05/24/23 at 9:22 AM, the surveyor interviewed LPN #1 who stated that the handwashing process involved washing hands for "about 20 seconds." LPN #1 further stated that the importance of proper hand hygiene was, "so you don't contaminate the Ex Order 26. 4B1". On 05/24/23 at 9:26 AM, the surveyor interviewed the Infection Preventionist (IP) who stated that staff should follow the handwashing procedure which included applying soap and using friction with their hands for at least 20 seconds. The IP further stated that the importance of proper hand hygiene was to prevent the spread of bacteria. When asked about LPN #1's hand hygiene competency, the IP stated she observed LPN #1's handwashing in April 2023 and that LPN#1 was not competent on the first attempt and had to repeat the handwashing demonstration to determine competency. On 05/24/23 at 9:39 AM, the surveyor interviewed	F 880	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.	

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F 880	Continued From page 77 the Director of Nursing (DON) who stated that the handwashing procedure included lathering hands with soap and applying friction for at least 20 seconds. The DON further stated the importance of proper hand hygiene was to prevent transferring germs from one resident to the next resident. Review of LPN #1's Personal Protective Equipment (PPE) Competency Validation, dated 04/20/23, revealed LPN#1 was not competent in hand hygiene twice during the observation. 2.) According to the Admission Record, Resident #83 had diagnoses which included, but were not limited to, *Ex Order 26. 4B1* [redacted] On 05/18/23 at 08:55 AM, in the [redacted] Hall of the [redacted] floor unit, the surveyor observed a Certified Nursing Assistant (CNA) use the wall mounted alcohol based hand rub, donned (put on) gloves, and then entered Resident #83's room. The CNA lifted the resident's [redacted], placed them on his/her bed, and then doffed her gloves and entered the resident's bathroom. The surveyor observed the CNA turn on the faucet to wet her hands, applied soap and lathered for 12 seconds, rinsed her hands, dried with a paper towel, and turned off the faucet with a clean paper towel.	F 880		

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F 880	Continued From page 78 During an interview at that time, the CNA stated that the handwashing process was to wet hands, lather with soap for 20 seconds, dry hands with a paper towel and turn off the faucet with a clean paper towel. When the surveyor informed the CNA that she lathered for 12 seconds, the CNA stated that she lathered for 20 seconds because she counted in her head or she hummed the song, "Three Little Bears". The CNA then rewashed her hands and while lathering turned to the surveyor and stated, "that was 20 seconds," at which point the surveyor revealed the stop watch time of 12 seconds. The CNA stated that it was possible that she counted differently each time she washed her hands and that it was important for infection control to wash her hands correctly anytime she had direct contact with a resident. On 05/24/23 at 09:00 AM, the surveyor interviewed LPN #2 who stated that the handwashing process included lathering hands with soap for 25-30 seconds and that it was to be performed any time a resident was touched or gloves were removed. LPN #2 stated she would know how long to properly lather by "singing the ABC's or Happy Birthday." The surveyor informed LPN #2 of the 05/18/23 CNA's handwashing observation and LPN #2 stated that 12 seconds was not long enough to lather and that, "it's the friction that counts, they were singing too fast." LPN #2 further stated that it was important to perform handwashing correctly to prevent the transfer of germs. On 05/24/23 at 09:22 AM, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM) who stated that the handwashing process included lathering hands with soap for 20	F 880		

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F 880	Continued From page 79	F 880		

seconds and that it was to be performed after any type of patient care. The RN/UM stated that she would know how long to properly lather by "singing Happy Birthday twice." The surveyor informed the RN/UM of the 05/18/23 CNA handwashing observation and the RN/UM stated that the CNA did not perform handwashing correctly because her timing was less than 20 seconds. The RN/UM further stated that there was a decreased risk of spreading disease when handwashing was correctly performed.

On 05/24/23 at 09:48 AM, the surveyor interviewed the DON who stated that the handwashing process included lathering hands with soap for 20 seconds and that it was to be performed after doing resident care and after doffing gloves. The DON stated she would know how long to properly lather by "singing Happy Birthday or counting the seconds." The surveyor informed the DON of the 05/18/23 CNA handwashing observation and the DON stated that the CNA did not perform handwashing correctly because she did not utilize the correct amount of lather time and that she should have lathered for 20 seconds. The DON further stated that it was important to handwash correctly to prevent spreading germs to the next person.

On 05/24/23 at 10:22 AM, the surveyor interviewed the IP who stated that the handwashing process included lathering hands with soap for, "not less than 20 seconds" and that it was to be performed before and after donning gloves and before and after touching a resident. The surveyor informed the IP of the 05/18/23 CNA handwashing observation and the IP stated that the CNA did not perform handwashing correctly because she only lathered for 12

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F 880	Continued From page 80 seconds and that she should have lathered for 20 seconds. The IP further stated that it was important to handwash correctly so that microorganisms were not transferred to other residents. Review of the CNA's Acknowledgement of Orientation documentation, dated 05/09/23, revealed that the CNA agreed to adhere to the Infection Prevention policy and procedure. Review of the facility's "Hand Hygiene Policy and Procedure," undated, included, "apply hand washing agent to hand," and, "vigorously rub hands together for at least 20 - 30 seconds, covering all surfaces of hands and fingers." NJAC 8:39-19.4(a)(1)	F 880		

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S 000	Initial Comments 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 DEFICIENCY AND ENSURE THAT THE PLAN IS IMPLEMENTED. FAILURE TO CORRECT DEFICIENCIES MAY RESULT IN ENFORCEMENT ACTION IN ACCORDANCE WITH THE PROVISIONS OF THE NEW JERSEY ADMINISTRATIVE CODE, TITLE 8, CHAPTER 43E, ENFORCEMENT OF LICENSURE REGULATIONS.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Complaints: NJ00163045 and NJ00163818 Based on interview and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios for the day shift, as mandated by the State of New Jersey. This was evident for a.) the complaint week of staffing from 03/26/2023 to 04/01/2023, the facility was deficient in Certified Nursing Aide (CNA) staffing for residents on one (1) of seven (7) day shifts, b.) the complaint week of staffing from 04/23/2023 to 04/29/2023, the facility was	S 560	Step 1 There was no negative outcome to residents on the shifts identified pertaining to the New Jersey staffing requirements during the day shift (7am-3pm) on 03/26/2023, 4/23/2023, and 4/30/2023. Step 2 All residents have the potential to be affected by the deficient practice of not meeting the New Jersey staffing requirement ratios.	6/14/23

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

Electronically Signed — 06/22/23

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S 560	Continued From page 1 deficient in CNA staffing for residents on one (1) of seven (7) day shifts and c.) the two (2) weeks of staffing prior to the standard survey from 04/30/2023 to 05/13/2023, the facility was deficient in CNA staffing for residents on one (1) of 14 day shifts. 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 (1) CNA to every eight (8) residents for the day shift. One (1) 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 (1) 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. The facility was deficient in CNA staffing for residents the day shifts as follows: 1. For the complaint week of staffing from 03/26/2023 to 04/01/2023, the facility was deficient in CNA staffing for residents on one (1)	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. C.N.A. rates have been evaluated and compared to neighboring facilities. The facility will do an assessment and determine if these salaries are comparable to like facilities nearby. 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 to ensure compliance with F 560. Step 4 The Administrator/designee will review the staffing schedule weekly to monitor the staffing on the 7-3pm shift for 8 weeks. The results of these audits will be reported 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.	

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 05/31/2023

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) COMPLETE DATE
S 560	Continued From page 2 of seven (7) day shifts as follows: -03/26/23 had 11 CNAs for 132 residents on the day shift, required 16 CNAs. 2. For the complaint week of staffing from 04/23/2023 to 04/29/2023, the facility was deficient in CNA staffing for residents on one (1) of seven (7) day shifts as follows: -04/23/23 had 14 CNAs for 133 residents on the day shift, required 17 CNAs. 3. For the two (2) weeks of staffing prior to the standard survey from 04/30/2023 to 05/13/2023, the facility was deficient in CNA staffing for residents on one (1) of 14 day shifts as follows: -04/30/23 had 15 CNAs for 130 residents on the day shift, required 16 CNAs. On 05/26/23 at 09:35 AM, the surveyor conducted a group interview with the Staffing Coordinator (SC), the Executive Director (ED) and the Director of Nursing (DON). The surveyor asked how has the staffing in the building been since the last survey? The SC stated, "Overall, the staffing hasn't been bad. We are dealing with staff callouts and no shows but try to stay in ratio as best we can." The surveyor asked, does the facility use agency staff? The SC stated, "Yes, we are using agency staff and we partner with multiple agencies." At that time, the surveyor continued the group interview and asked, what percentage of staff are agency staff? The ED stated, "We're around 75% maybe slightly higher with agency staff. The agencies do well with suppling CNAs." The surveyor asked does the facility provide training for agency staff? The ED stated, "We provide an orientation and on-going	S 560		

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 05/31/2023

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SILVER HEALTHCARE CENTER	1417 BRACE ROAD CHERRY HILL, NJ 08034

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S 560	Continued From page 3	S 560		

training for areas such as: abuse and transfer training." The surveyor asked what was the facility doing to increase in-house staffing? The ED replied, "We did hire a new HR (Human Resources) manager, with the primary focus of recruiting new staff and employee retention." The DON then stated, "We have partnered with a CNA training school to increase hires and starting a preceptor program." The ED stated, "We are also providing frequent fun activities for current staff to keep increased morale. We are also finishing up two (2) wage analyses to adjust current wages and rates." The ED further stated, "We are continuing with annual bonuses, weekend and shift differential." The ED stated, "We are posting job openings on [name of company] and other employment websites. We did go to a job fair at [name of school] and had some success. We will be doing an internal job fair with the hope of trying to fix the previous repetition. We are offering employee referrals of $250 CNA and $500 LPN/RN (Licensed Practical Nurse/Registered Nurse)." The DON emphasized, "We are desperately trying to hire more staff and be less reliant on agencies, we are hoping to reduce that 75% number."

A review of the job description of the SC signed and dated 11/22/2022, included, "The SC is responsible for coordinating the scheduling of designated facility employees and obtaining supplemental staffing through the assigned staffing agency, to meet the required staffing needs to care for the residents ...."

A review of the facility's Emergency Staffing policy revised 10/2022, included, "In the event of a staffing emergency, where there is a significant shortage or staff and the facility cannot meet the required staffing levels, the Administrator, or

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S 560	Continued From page 4 Director of Nursing will make the decision to utilize emergency staffing strategies as necessary to provide for care and treatment of residents." On 05/31/23 at 09:04 AM, the survey team observed that the staffing was posted throughout the duration of the survey. NJAC 8:39-5.1(a)	S 560		

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 _____	R-C 07/20/2023

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{E 000}	Initial Comments An onsite revisit was conducted on 7/20/2023 to verify the faclity's POC regarding the 5/31/2023 Recertification survey. The facility was found in compliance.	{E 000}		
{F 000}	INITIAL COMMENTS	{F 000}		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315280 Y1	A. Building B. Wing Y2	7/20/2023 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 F0656 Reg. # 483.21(b)(1)(3) LSC	Correction Completed 06/14/2023	ID Prefix F0684 Reg. # 483.25 LSC	Correction Completed 06/14/2023	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	
5/31/2023	☐ 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	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315280 Y1	A. Building B. Wing Y2	7/20/2023 Y3

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

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0609	Correction	ID Prefix F0641	Correction	ID Prefix F0644	Correction
Reg. # 483.12(b)(5)(i)(A)(B)(c)(1)(4)	Completed	Reg. # 483.20(g)	Completed	Reg. # 483.20(e)(1)(2)	Completed
LSC	06/14/2023	LSC	06/14/2023	LSC	06/14/2023
ID Prefix F0656	Correction	ID Prefix F0684	Correction	ID Prefix F0688	Correction
Reg. # 483.21(b)(1)(3)	Completed	Reg. # 483.25	Completed	Reg. # 483.25(c)(1)-(3)	Completed
LSC	06/14/2023	LSC	06/14/2023	LSC	06/14/2023
ID Prefix F0689	Correction	ID Prefix F0695	Correction	ID Prefix F0755	Correction
Reg. # 483.25(d)(1)(2)	Completed	Reg. # 483.25(i)	Completed	Reg. # 483.45(a)(b)(1)-(3)	Completed
LSC	06/01/2023	LSC	06/14/2023	LSC	06/14/2023
ID Prefix F0761	Correction	ID Prefix F0812	Correction	ID Prefix F0880	Correction
Reg. # 483.45(g)(h)(1)(2)	Completed	Reg. # 483.60(i)(1)(2)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed
LSC	06/14/2023	LSC	06/14/2023	LSC	06/14/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO
5/31/2023	

New Jersey Department of Health

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 _____	R-C 07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{S 000}	Initial Comments An onsite revisit was conducted on 7/20/2023 to verify the faclity's POC regarding the 5/31/2023 Recertification survey. The facility was found in compliance.	{S 000}		

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

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
060407	A. Building B. Wing	7/20/2023

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 State surveyor to show those deficiencies previously reported 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 State Survey Report (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 S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 06/14/2023	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	
5/31/2023	☐ 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 _____	**05/31/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 293 SS=D	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and review of facility provided documentation on 05/24/2023, 05/25/2023, and 05/26/2023 in the presence of facility management, it was determined that the facility failed to ensure that illuminated exit signs were in two (2) locations to clearly identify the exit access path to reach an exit discharge door.	K 293	Element 1 The two exit signs (Atrium Dining Room Courtyard) will be placed above the doors on the exterior of the building courtyard to show direction of exit. Element 2	7/14/23

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

Electronically Signed | 06/22/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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 _____	**05/31/2023**

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K 293	Continued From page 1 This deficient practice was evidenced by the following: Reference: NFPA. Life Safety Code 2012 7.10.1.5.1 Exit Access. Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach the exit is not readily apparent to the occupants. NFPA Life Safety Code 2012 7.10.5.2.1 Continuous Illumination. Every sign required to be illuminated by 7.10.6.3, 7.10.7, and 7.10.8.1 shall be continuously illuminated as required under the provisions of section 7.8, unless otherwise provided in 7.10.5.2.2 On 05/24/2023 (day one of survey) during the survey entrance at approximately 8:41 AM, a request was made to the and Maintenance Director (MD) to provide a copy of the facility lay-out which identified the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified there were three (3) buildings that were connected together, the Atrium, the Pavilion and the Court buildings. The Atrium building had two (2) outside enclosed (surrounded by the building) center courtyards. Starting at approximately 9:23 AM on 05/24/2023 and continued on 05/25/2023 and 05/26/2023, in the presence of the facility's MD a tour of the facility was conducted. On 05/26/2023 (day 3 of survey) during an inspection of the Atrium building in the presence of the MD at approximately 10:31 AM, an	K 293	All residents have the potential to be affected by the deficient practice. Element 3 An audit was conducted, and no other areas were identified. Element 4 Maintenance Director/designee will conduct monthly audits for two months to ensure that all exterior doors exit signs are installed and in working order. The results of these audits will be reported 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.	

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 _____	**05/31/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 293	Continued From page 2 inspection in the outside "Small" smoking courtyard was was performed. The surveyor observed no evidence of two (2) illuminated exit signs above the two (2) exit access doors that lead out of the enclosed center court yard. This was a primary and/or secondary exit access route to reach an exit. The MD confirmed the findings at the time of observations. The Administrator and Corporate Vice President of Environmental Services was informed of the findings at the Life Safety Code Exit conference on 5/26/23 at approximately 12:45 PM.	K 293		
K 321 SS=D	Fire Safety Hazard. NJAC 8:39 -31.1 (c) NFPA Life Safety Code 101 Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door.	K 321		6/15/23

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	315280	A. BUILDING **01** B. WING _____	**05/31/2023**

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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 321	Continued From page 3 Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and review of facility provided documentation on 05/24/2023, 05/25/2023 and 05/26/2023 in the presence of facility management, it was determined that the facility failed to ensure that fire-rated doors to hazardous areas were self-closing, and were separated by smoke resisting partitions in accordance with NFPA 101, 2012 Edition, Section 19.3.2.1, 19.3.2.1.3, 19.3.2.1.5, 19.3.6.3.5, 19.3.6.4, 8.3, 8.3.5.1, 8.4, 8.5.6.2 and 8.7. This deficient practiced was evidenced by the following: On 05/24/2023 (day one of survey) during the survey entrance at approximately 8:41 AM, a request was made to the and Maintenance Director (MD) to provide a copy of the facility lay-out which identified the various rooms and smoke compartments in the facility.	K 321	Element 1 The automatic door closing mechanism was replaced on the door to room 336, allowing it to self close while being utilized as a storage area. The rubber door wedge was removed to allow the door to self-close. The door/frame will be repaired to ensure proper closing/latching. Element 2 All residents have the potential to be affected by the deficient practice. Element 3 Staff will be educated not to use items to keep doors propped open. The maintenance director did an audit on all storage areas, and no other issues were identified. Element 4	

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K 321	Continued From page 4 A review of the facility provided lay-out identified there were three (3) buildings that were connected together, the Atrium, the Pavilion and the Court buildings. Starting at approximately 9:23 AM on 05/24/2023, continued on 05/25/2023 and 05/26/2023 in the presence of the facility's MD a tour of the facility was conducted. Along the three (3) day tour of the facility the surveyor observed the following hazardous area that failed to have smoke resisting doors, 1.) On 05/25/2023 at approximately 11:46 AM, an inspection of the first floor commercial laundry area was performed. The surveyor observed that the fire rated door leading into the dryer area was propped in the open position with a rubber door wedge. When the surveyor removed the rubber door wedge and allowed the door to self-close, the door rubbed on the floor and stopped short of the frame. The surveyor measured and recorded the opening at twenty (20") inches between the door and the frame. This closure test was conducted two (2) additional times with the same results. The commercial laundry room was larger than 100 square feet. A review of an emergency evacuation diagram posted in the corridor showed the corridor the egress access corridor to reach an exit. 2.) On 05/26/2023 at approximately 10:44 AM, the surveyor inspected the Atrium building resident room #336. The surveyor observed room #336 was utilized as a storage and Personal Protective Equipment (PPE) storage room. At that	K 321	The Maintenance Director/designee will conduct monthly door audits for two months to ensure all storage areas have self-closing mechanisms in working order. The results of these audits will be reported 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.	

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K 321	Continued From page 5 time, the surveyor observed that the doors automatic door closure had been disconnected. The surveyor observed inside the room approximately 18 cases of vinyl gloves, approximately 36 cases (12 rolls per case) of toilet tissue and approximately 30 combustible cardboard boxes. The room was larger than 50 square feet. A review of an emergency evacuation diagram posted in the corridor showed the corridor and the egress access corridor to reach an exit. With these corridor doors not self-closing into their frames, this would allow fire, smoke and poisonous gases to pass into the exit access corridor in the event of a fire. The MD confirmed the findings at the time of observations. The Administrator and Corporate Vice President of Environmental Services was informed of the findings at the Life Safety Code Exit conference on 5/26/23. NJAC 8:39-31.2 (e) Life Safety Code 101	K 321		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available.	K 345		6/14/23

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K 345	Continued From page 6 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on interview and review of facility provided documentation on 05/24/23, 05/25/2023 and 05/26/2023 in the presence of facility management, it was determined that the facility failed to conduct smoke detection sensitivity testing every alternate year in accordance with NFPA 72 National Fire Alarm and Signaling Code (2010 edition) section 14.4.5.3.2. The deficient practice was evidenced by the following: On 05/24/2023 (day one of survey) during the survey entrance at 8:41 AM, a request was made to the Administrator and Maintenance Director (MD) to provide all mandatory inspections from June 1, 2022 through May 24, 2023 for review later. The surveyor also made a request to the MD to provide a copy of the last smoke detector sensitivity testing. Starting at approximately 9:23 AM, in the presence of the facility MD a tour of the facility was conducted. During the building tour the surveyor observed smoke detectors were in the corridors, in all sleeping rooms and other concealed areas throughout the building. Later at approximately 12:15 PM, a review of the facility provided fire alarm and detection system inspection reports dated 1/17/2023, 8/02/2022 and 1/24/2022 was performed. The reports provided did not indicate any information on the testing of the smoke detector's for sensitivity.	K 345	Element 1 The Smoke sensitivity test was conducted on 5/30/2023 by ARK Protective Services. The report showed that the smoke detectors were operational, and no recommendations were made by the vendor. Element 2 All residents have the potential to be affected by the deficient practice. Element 3 The Smoke sensitivity report was reviewed by the Maintenance Director and no recommendations were noted, and the facility passed the smoke sensitivity report. Element 4 The Maintenance Director/designee will audit the smoke sensitivity report annually to ensure compliance.	

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K 345	Continued From page 7 The MD stated he would contact the facility fire alarm vendor to see if a sensitivity report was performed. On 05/25/2023 at approximately 10:45 AM, the MD told the surveyor that he called the vendor to obtain a copy of the last sensitivity testing. The MD said, the fire alarm and detection vendor told him that they have been inspecting the buildings fire alarm system for 10 years and have never conducted a smoke detector sensitivity testing. The Administrator and Corporate Vice President of Environmental Services was informed of the findings at the Life Safety Code Exit conference on 5/26/23. NJAC 8:39-31.1(c) NJAC 8:39-31.2(e) NFPA 70, 72	K 345		
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 05/24/2023, 05/25/2023 and 05/26/2023 in the presence of facility management, it was determined that the facility failed to: a.) perform a monthly examination for 2 of 43 portable fire extinguishers, as required by National Fire Protection Association NFPA 101,	K 355	Element 1 The fire extinguisher inside the 1st floor court building storage room (near the commercial laundry area) monthly visual inspections could not be corrected. The fire extinguisher inside the 1st floor Court elevator mechanical rooms previous	6/14/23

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K 355	Continued From page 8 2012 Edition, Section 19.3.5.12, 9.7.4.1 and National Fire Protection Association (NFPA)10, 2010 Edition, Sections 4- 3, 4- 3.1, 4- 3.3 and 4-3.4 and N.J.A.C. 5:70. and b.) maintain 1 of 43 fire extinguishers in proper working condition. Reference #1 NFPA 10 Edition 2010 Standard for portable fire extinguishers reads, - 4- 3 Inspection Maintenance. - 4- 3.1 Frequency. Fire extinguishers shall be inspected when initially placed in service and thereafter 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 05/24/2023 (day one of survey) during the survey entrance at approximately 8:41 AM, a request was made to the and Maintenance Director (MD) to provide a copy of the facility lay-out which identified the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified	K 355	monthly inspections could not be corrected. The MD reviewed the current monthly visual inspection, and it was up to date. The fire extinguisher in the Court 1 corridor near the Director of Nursing Office was replaced by the MD on 5/25/2023. Element 2 All residents have the potential to be affected by the deficient practice. Element 3 The Maintenance Department will be educated by the Regional Maintenance Director on monthly fire extinguisher inspection reports, and to replace fire extinguishers that indicate low pressure. An audit was conducted on 6/5/2023 on fire extinguishers, checking low pressure indicators and monthly visualization inspections. No issues were identified. Element 4 The Maintenance Director/designee will conduct monthly visualization inspections on fire extinguishers for 2 months to ensure that the plastic safety band is intact, the hose is intact, and the gauge shows proper operation pressure. The results of audits will be reported to the QAPI committee monthly to ensure compliance. The results will be used for additional training and system changes if necessary.	

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K 355	Continued From page 9 there were three (3) buildings that are connected together, the Atrium, the Pavilion and the Court buildings. Starting at approximately 9:23 AM on 05/24/2023, continued on 05/25/2023 and on 05/26/2023 in the presence of the facility's MD a tour of the facility was conducted. Along the three day tour of the facility the surveyor observed and inspected forty three (43) portable fire extinguishers that were last annually inspected July 2022 in various locations with the following issues were identified: On 05/25/2023: 1.) At approximately 11:54 AM, One (1) "ABC-Type" fire extinguisher inside the 1st floor Court building storage room (near the commercial laundry area) was last annually inspected July 2022 was missing monthly visual examination performed and documented for February, March and April 2023. 2.) At approximately 12:03 PM, One (1) "ABC-Type" fire extinguisher inside the 1st floor Court elevator mechanical room was last annually inspected July 2022 was missing monthly visual examination performed and documented for September, October, November and December 2022 and 2023. 3.) At approximately 12:20 PM, One (1) "ABC-Type" fire extinguisher in the Court 1 corridor near the Director of Nursing office, pressure indicating needle was in the "RED" discharge zone on the gauge. At this time the surveyor asked the MD if the facility had a spare fire extinguisher to exchange. The MD said, yes and complied with the request.	K 355		

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K 355	Continued From page 10 This fire extinguisher would not have functioned properly in the event of a fire. The MD confirmed the findings at the time of observations. The Administrator and Corporate Vice President of Environmental Services was informed of the findings at the Life Safety Code Exit conference on 5/26/23. NFPA 10 NJAC 8:39 -31.1 (c), 31.2 (e).	K 355		
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. 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	K 363		7/14/23

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K 363	Continued From page 11 pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation on 05/24/2023, 05/25/2023 and 05/26/2023, in the presence of facility management it was determined that the facility failed to ensure that 9 of 34 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. The evidence includes the following: On 05/24/2023 (day one of survey) during the survey entrance at approximately 8:41 AM, a request was made to the and Maintenance Director (MD) to provide a copy of the facility lay-out which identified the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified there were three (3) buildings that were connected together, the Atrium, the Pavilion and	K 363	Element 1 1. The door on the Pavilion near the central shower room, the door on the 2nd floor Court building Resident room 255, the 2nd floor Court building resident room 257, and the 1st floor Court building at the Environmental Services Directors office door gaps will be assessed by a contractor for replacement/repairs to ensure that these doors are able to resident the passage of smoking in accordance with the requirements of NFPA 101. 2. The doorknobs on the Atrium Soiled utility room, activity storage room, resident room 342, and resident room 344 will be replaced to ensure that these doors are able to resident the passage of smoking in accordance with the requirements of NFPA 101.	

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K 363	Continued From page 12 the Court buildings. The Atrium building had 43 Resident sleeping rooms, the Pavilion building had 23 Resident sleeping rooms and the Court building had 82 Resident sleeping rooms. Starting on 05/24/2023 at approximately 9:23 AM, continued on 05/25/2023 and 05/26/2023, in the presence of the facility's MD a tour of the facility was conducted. A review of the facility provided lay-out identified the facility is a two-story building with a basement. There were 117 resident sleeping rooms on the 1st. and 2nd. floors. During the three (3) day tour of the facility the surveyor performed closure tests of the thirty four (34) doors in the corridors and identified the following results: On 05/24/2023: 1.) At approximately 10:08 AM, in the Pavilion buildings Central Shower room, during a closure test of the corridor door there was a 1/4" (inch) 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. On 05/25/2023: 2.) At approximately 11:13 AM, on the 2nd. floor Court building Resident room #255, during a closure test of the corridor door there was a 1/2" 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.	K 363	Element 2 All residents have the potential to be affected by the deficient practice. Element 3 The Maintenance department will be educated on K 363, identifying door gaps during monthly door audits, and not removing doorknobs from rooms that are not currently being utilized to ensure compliance with K 363. An audit was conducted on Atrium doors on 6/5/2023 and no other doors were missing doorknobs. An audit was completed on 6/5/2023 on doors to ensure that doors are free from gaps that could potentially allow fire, smoke and poisonous gases to pass into the exit access corridor in the event of a fire. No other areas were identified. Element 4 Maintenance Director/designee will audit doors monthly for two months to ensure that doors do not have exposed gaps or penetration that would allow smoke or gases to pass in the event of a fire. Maintenance Director/designee will audit doors monthly for two months to ensure that there are no penetrations to allow smoke or gases to pass in the event of a fire. The results of these audits will be reported 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.	

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K 363	Continued From page 13 3.) At approximately 11:15 AM, on the 2nd. floor Court building Resident room #257, during a closure test of the corridor door there was a 5/8" 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. 4.) At approximately 11:15 AM, on the 2nd. floor Court building Environmental Services Directors office, 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. The MD confirmed the findings at the times of observations. On 05/26/2023: 5.) At approximately 9:54 AM, in the Atrium building the Soiled utility room door had no door knob leaving a 2-1/8" inch opening. This would allow fire, smoke and poisonous gases to pass into the exit access corridor in the event of a fire. 6.) At approximately 10:25 AM, in the Atrium building the activity storage room door had no door knob leaving a 2-1/8" inch opening. This would allow fire, smoke and poisonous gases to pass into the exit access corridor in the event of a fire. 7.) At approximately 10:35 AM, in the Atrium	K 363		

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K 363	Continued From page 14 building the Resident room #342 corridor door had no door knob leaving a 2-1/8" inch opening. This would allow fire, smoke and poisonous gases to pass into the exit access corridor in the event of a fire. 8.) At approximately 10:36 AM, in the Atrium building the Resident room #344 corridor door had no door knob leaving a 2-1/8" inch opening. This would allow fire, smoke and poisonous gases to pass into the exit access corridor in the event of a fire. The Corporate Vice President of Environmental Services acknowledged the findings on 05/26/2023. The Administrator and Corporate Vice President of Environmental Services was informed of the findings at the Life Safety Code Exit conference on 5/26/23. 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 374 SS=D	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window	K 374		7/14/23

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 374	Continued From page 15 assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observations and review of facility provided documentation on 05/24/2023, 05/25/2023 and 05/26/2023, it was determined that the facility failed to maintain smoke barrier doors to resist the transfer of smoke when completely closed for fire protection. This deficient practice was identified for 1 of 16 sets of corridor smoke barrier doors tested and was evidenced by the following: Reference 1: Life Safety Code 101, 2012 Edition, - 8.5.4.1, Doors in smoke barriers shall close the opening, leaving only the minimum clearance necessary for proper operation, and shall be without louvers or grills. The clearance under the bottom of a new door shall be a maximum of 3/4 of an inch. On 05/24/2023 (day one of survey) during the survey entrance at approximately 8:41 AM, a request was made to the and Maintenance Director (MD) 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.	K 374	Element 1 The double smoke doors in the Atrium building□s corridor next to the resident spa will be assessed by a licensed contractor for replacement/repairs to ensure that these doors are able to close without significant gaps that would allow the transfer of smoke, fire and gases to pass from one smoke department to another in the event of a fire. Element 2 All residents have the potential to be affected by the deficient practice. Element 3 An audit was completed on 6/5/2023 on doors to ensure that doors are free from gaps that could potentially allow fire, smoke and poisonous gases to pass into the exit access corridor in the event of a fire. No other areas were identified. The Maintenance department will be educated on K 374, identifying door gaps during monthly door audits to ensure compliance. Element 4 The Maintenance Director/designee will audit doors monthly for two months to	

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	315280	A. BUILDING **01** B. WING _____	**05/31/2023**

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K 374	Continued From page 16 There are 16 sets of corridor smoke doors in the facility. Starting at approximately 9:23 AM on 05/24/2023, continued on 05/25/2023 and 05/26/2023, in the presence of the facility's MD a tour of the facility was conducted. Along the three (3) day tour the surveyor performed a closure test of sixteen (16) sets of double smoke doors in the corridors with the following results, On 05/26/2023: 1.) At approximately 10:36 AM, during a closure test of the double smoke doors in the Atrium building's corridor next to Resident Spa, when the doors were released from the magnetic hold open device and allowed to self close into their frame, the surveyor observed and measure a 3/8 inch wide by 10 inch high gap along the bottom meeting edge of the doors. This test was repeated two additional times with the same results. This would allow the transfer of smoke, fire and poisonous gasses to pass from one smoke compartment to another in the event of a fire. The MD confirmed the findings at the time of observations. The Administrator and Corporate Vice President of Environmental Services was informed of the findings at the Life Safety Code Exit conference on 5/26/23 at approximately 12:45 PM. N.J.A.C. 8:39-31.1(c), 31.2(e)	K 374	ensure that the doors are free of significant gaps that would allow smoke, fire and gases to pass from one smoke department to another in the event of a fire. The results of audits will be reported to the QAPI committee monthly to ensure compliance. The results will be used for additional training and system changes if necessary.	
K 521 SS=D	HVAC	K 521		6/30/23

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	315280	A. BUILDING **01** B. WING _____	**05/31/2023**

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

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K 521	Continued From page 17 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 05/24/2023, 05/25/2023 and 05/26/2023 in the presence of facility management, it was determined that the facility failed to ensure that the facility's ventilation systems were being properly maintained for 2 of 14 Resident bathroom exhaust systems as per the National Fire Protection Association (NFPA) 90A. This deficient practice was evidenced by the following: On 05/24/2023 (day one of survey) during the survey entrance at approximately 8:41 AM, a request was made to the and Maintenance Director (MD) to provide a copy of the facility lay-out which identified the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified there are three (3) buildings that were connected together, the Atrium, the Pavilion and the Court buildings. Starting at approximately 9:23 AM on 05/24/2023,	K 521	Element 1 A licensed contractor will be contacted to assess and repair/replace the exhaust system in room 248 and 251. Element 2 All residents have the potential to be affected by the deficient practice. Element 3 An audit was conducted on 6/5/2023 on bathroom exhaust systems, and no other issues were found. Element 4 Maintenance director/designee will audit resident bathroom exhaust systems to ensure proper functioning of vent monthly for two months. The results of these audits will be reported 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.	

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K 521	Continued From page 18 continued on 05/25/2023, and 05/26/2023 in the presence of the facility's MD, a tour of the facility was conducted. Along the three (3) day tour of the facility the surveyor inspected and tested eleven (11) Resident sleeping room bathrooms and three (3) shower room bathroom exhaust systems. 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 was present), the exhaust did not function properly in 2 of 14 resident bathrooms in the following locations: On 05/24/2023: 1.) At approximately 11:33 AM, inside Resident room #248 bathroom, when tested the exhaust system did not function properly. At that time, the surveyor informed the MD that 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. On 05/25/2023: 2.) At approximately 11:30 AM, inside Resident room #251 bathroom, when tested the exhaust system did not function properly. This bathroom had no window with an area that would open. This bathroom would rely on mechanical ventilation. The MD confirmed the findings at the time of observations. On 05/26/2023 during the Life Safety Code survey exit at approximately 12:45 PM, the surveyor informed the Administrator and	K 521		

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K 521	Continued From page 19 Corporate Vice President of Environmental Services of the deficiency. NFPA 90A. NJAC 8:39- 31.2 (e).	K 521		
K 781 SS=D	Portable Space Heaters CFR(s): NFPA 101 Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 This REQUIREMENT is not met as evidenced by: Based on observation on 05/26/2023 in the presence of facility management, it was determined that the facility failed to ensure portable electric heaters were not used with a heating element exceeding 212 degrees Fahrenheit (100 degrees Celsius). This deficient practice was evidenced for 1 of 1 heater and was evidenced by the following: On 05/26/2023 during the building tour in the presence of the facility's Maintenance Director (MD) at approximately 9:41 AM, the surveyor observed in an office next to the Admissions office that one (1) portable electric heater was plugged into the duplex wall outlet. The heater was on at the time of the observation and had an open grill that provided an exposed heating element that exceeded 212 degrees Fahrenheit. The MD confirmed the portable electric heater was on and indicated that the heater should not	K 781	Element 1 The heater in the office adjacent to the admission office was removed. Element 2 All residents have the potential to be affected by the deficient practice. Element 3 Staff will be educated on K 781 and portable space heater devices are prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit. A walk-through audit of staff offices was conducted 6/5/2023 to ensure heaters were not present. No other issues were identified.	6/15/23

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K 781	Continued From page 20 be used in the facility at any time. The MD un-plugged the heater and removed it from the office. The Administrator and Corporate Vice President of Environmental Services was informed of the findings at the Life Safety Code Exit conference on 5/26/23 at approximately 12:45 PM. NJAC 8:39-31.2(e) NFPA 101 2012 edition Life Safety Code 19.7.8 (1) & (2) Portable Space-Heating Devices	K 781	Element 4 Maintenance director/designee will conduct random staff-office/room audits to ensure portable space heaters are not present that exceed 212 degrees F. weekly for 8 weeks to ensure compliance with K 781. The results of these audits will be reported 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.	
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 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	K 918		6/15/23

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K 918	Continued From page 21 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: Based on interview, document review and facility policy review on 05/02/2023 and 05/03/2023, it was determined the facility failed to: a.) exercise the emergency generator 12 times each year for at least 30 minutes in 20 to 40 day intervals and b.) document the time needed by the generator to transfer power to the building was within the 10-second time frame in accordance with National Fire Protection Association (NFPA) 99 and 110. This deficient practice is evidenced by the following: On 05/24/2023 (day one of survey) during the survey entrance at 8:41 AM, a request was made to the Administrator and Maintenance Director (MD) to provide all mandatory inspections from June 1, 2022 through May 24, 2023 for review later. The surveyor also made a request to the MD if the facility had an emergency generator, and how often do they run the generator. The MD stated, "Yes we have four (4) emergency generators here. Three (3) are for the Nursing home and one	K 918	Element 1 The load testing for September, October, November and December of 2022 could not be corrected. Element 2 All residents have the potential to be affected by the deficient practice. Element 3 The maintenance director reviewed the logbook, and the load has been conducted monthly since December 2022. Maintenance staff will be trained by the Executive Director on K 918 to ensure compliance. Element 4 The Executive Director will audit monthly logs for generator load tests to ensure compliance monthly for two months. The results of these audits will be reported to the QAPI committee monthly. Results of audits will be reported to the QAPI committee to ensure compliance. The	

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K 918	Continued From page 22 (1) generator is for the Dialysis Center". The surveyor asked the MD does the facility document the load tests for the three (3) emergency generators for the Nursing Home and if they do could the facility provide the log for the previous 12 months for review later? The MD told the surveyor yes they had log books. On 05/25/2023 at approximately 1:23 PM, the surveyor reviewed the three (3) generator log books provided by the facility. A review of the three (3) "Emergency Generator Inspection Monthly Log" for the previous 12 months indicated there was no documented certification that the generator would start and transfer power to the building within ten seconds, since no load test was conducted for September, October, November and December 2022. The Corporate Vice President of Environmental Services acknowledged the findings on 05/26/2023. The Administrator and Corporate Vice President of Environmental Services was informed of the findings at the Life Safety Code Exit conference on 5/26/23 at approximately 12:45 PM. NJAC 8:39-31.2(g)	K 918	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 01 - MAIN BUILDING 01 B. Wing Y2	7/20/2023 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 K0293	07/14/2023	LSC K0321	06/15/2023	LSC K0345	06/15/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0355	06/15/2023	LSC K0363	07/14/2023	LSC K0374	07/14/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0521	06/30/2023	LSC K0781	06/15/2023	LSC K0918	06/15/2023
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	
5/31/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO