STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315280	A. BUILDING _____ B. WING _____	C 08/13/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

REVISED

Complaint #: NJ145040, NJ144427, NJ141661, NJ142926, NJ145386, NJ145690, NJ135912, NJ145455, NJ145806, NJ145778,

Census: 147

Sample Size: 21

The facility is not in compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities based on this complaint survey.

The facility failed to provide a safe environment to prevent resident-to-resident abuse for 5 (Residents #3, #14, #15, #16, and #17) of 5 sampled residents for resident-to-resident abuse. Resident #13 had a diagnosis of NJ Exec. Order 26:4.b.1 and was NJ Exec. Order 26:4.b.1. Residents #3, #14, #15, #16, and #17 were assaulted by Resident #13. Some of the assaults resulted in NJ Exec. Order 26:4.b.1 .

It was determined the facility's non-compliance with one or more requirements of participation caused, or was likely to cause, serious injury, harm, impairment, or death to residents. The Immediate Jeopardy (IJ) was related to State Operations Manual, Appendix PP, §483.12 (Freedom from Abuse, Neglect and Exploitation) at a scope and severity of "J."

The IJ began on 07/29/2021 when the resident's physician indicated the resident was no longer

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

Electronically Signed | 08/27/2021

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315280	A. BUILDING _____ B. WING _____	C 08/13/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1	F 000		

NJ Exec. Order 26:4.b.1

The resident NJ Exec. Order 26:4.b.1 but the resident remained in the facility. The resident assaulted another resident on 08/08/2021.

On 08/08/2021 at 12:00 PM, an IJ was identified. At 5:16 PM, the facility Administrator and Assistant Director of Nurses (ADON) were provided with the completed IJ template and notified of the existence of an IJ for abuse. The Administrator signed the template and returned the original to the survey team.

On 08/11/2021 at 1:41 PM, a Removal Plan was accepted by the New Jersey Department of Health (NJDOH).

The IJ continued until 08/09/2021 at 10:00 PM, when the facility alleged the elements of the Removal Plan had been implemented.

On 08/13/2021 at 9:30 AM, a surveyor conducted an onsite revisit to verify the Removal Plan had been implemented. Resident #13 had been removed from the facility on NJ Exec. Order 26 4.b.1. The facility implemented the Removal Plan, which included education for certified nursing assistants (CNAs), nursing assistants (NAs), and licensed nursing staff for the Atrium, Court Two, and Pavilion and Vent Units on how to properly monitor residents who were on one-to-one behavior monitoring. CNAs, NAs, and licensed staff were being educated on staying within arm's reach of a resident, never leaving a resident alone, ensuring that the one-to-one was covered by another staff member when going to break, and documenting whereabouts and behaviors.

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315280	A. BUILDING _____ B. WING _____	C 08/13/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 2 The facility had an updated seating chart of the Pavilion Unit to include any resident on one-to-one will have a seating plan during meals and recreational activities to lessen the chance of another resident being harmed by impulsive behaviors. The facility will continue with the current psychiatry group for continuity of care. The noncompliance remained on 08/13/2021 for "no actual harm with the potential for more than minimal harm that is not immediate jeopardy" based on the following: The facility had not implemented all areas of the Removal Plan that included the "at-risk" weekly meeting to discuss behaviors, care plans, and possibly new interventions, and the monthly psychotropic meetings with psychiatrists, Director of Nursing (DON), Assistant Director of Nursing (ADON), and Unit Managers (UMs) to discuss any actual and potential issues which may include medication changes or additional interventions.	F 000		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the	F 584		8/30/21

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315280	A. BUILDING _____ B. WING _____	C 08/13/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 3 physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Complaint Intake NJ144427 Based on observations, interviews, and facility procedure review, it was determined that the facility failed to clean debris from resident room floors for 3 (Room 212, Room 214, and Room 217) of 3 rooms observed on Court Two Hallway A. Findings included:	F 584	There were no specific residents effected by this deficient practice All residents are at risk for this alleged deficiency. We made sure every room was cleaned right away and had the Housekeeping Director inspect them to confirm. To ensure that this does not reoccur, the housekeeping director educated staff on proper rounding and clean up routines. To monitor the corrective action: The	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315280	A. BUILDING _____ B. WING _____	C 08/13/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 4 1. During a tour of Court Two Hallway A on 08/06/2021 at 1:20 PM, open doors to Room 212 revealed an observation of debris on the floor which included bits of paper, a tissue, and dirt. An open door to Room 214 revealed an opened clear plastic wrapper on the floor under a raised bed and general debris of bits of paper and dirt. An open door to Room 217 revealed many black rectangular pieces of debris over half the open floor space and other bits of paper debris. On 08/06/2021 at 1:32 PM, an interview was conducted with Housekeeper #1 on Court Two Hallway B. The housekeeper stated she had been assigned to clean Hallway B for the last couple of months. The housekeeper stated she did not clean Hallway A, and the housekeeper who cleaned Hallway A did not come to work today. Housekeeper #1 stated she did not know who would clean Hallway A. On 08/07/2021 at 9:44 AM, an interview was conducted with Housekeeper #3, who was observed on Court Two Hallway B. The housekeeper stated she was not the housekeeper of Court Two and was supposed to be working in the laundry. The housekeeper stated she had been told to come to the floor to be a presence in the hallway since someone was in the building. The housekeeper indicated she was not really here to clean all these rooms. On 08/07/2021 at 1:27 PM, an observation from Hallway A into open doors of resident rooms revealed Room 212 still had bits of paper and general debris on the floor, Room 214 still had a clear plastic opened wrapper on the floor along with bits of paper and debris, and Room 217 still had a large amount of rectangular black debris	F 584	housekeeping Director will continue to audit at least 3x a week randomly x6 weeks. To ensure all rooms are being properly cleaned we will be reviewing these audits by the QA meetings for the next 2 quarters. The Administrator and Housekeeping Director will be responsible for this plan of correction. Substantial compliance will be achieved by 08/30/2021	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315280	A. BUILDING _____ B. WING _____	C 08/13/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 5	F 584		

and bits of paper on the floor.

On 08/07/2021 at 1:33 PM, an observation was made of the debris visible in Room 217 with Licensed Practical Nurse (LPN) #3 and Unit Manager (UM) #3. The LPN and UM stated they did not know the schedule of housekeepers and had not seen a housekeeper on the unit this day. The LPN and UM did not know what the substance was on the floor of Room 217 but stated they would have a housekeeper come up to clean it.

On 08/08/2021 at 8:17 AM, an interview was conducted with the Administrator. The Administrator stated that each housekeeper had about 15 rooms to clean, and the rooms were cleaned daily. The housekeeper director was not in the building this weekend. The facility was still in the process of actively looking to hire more housekeepers.

On 08/09/2021 at 10:33 AM, an interview was conducted with Housekeeper #5. The housekeeper stated she was scheduled to clean Court Two Hallway A for the past two months. The housekeeper stated she was off this past weekend, and the rooms did not appear as if they had been cleaned, and the floors were very dirty.

On 08/09/2021 at 11:44 AM, an interview was conducted with the Housekeeping Director (HD). The HD stated this weekend he had housekeeping staff call out and one staff resigned. The HD stated Housekeeper #3 was assigned as a floater to clean Court Two halls when the regular staff were off. The HD stated he expected the resident rooms to be cleaned daily.

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315280	A. BUILDING _____ B. WING _____	C 08/13/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 6 A review of the facility procedure, titled, Cleaning Methods-Housekeeping, updated on 05/17/2021, included under Standard: Cleaning of residents' rooms will be performed daily. New Jersey Administrative Code § 8:39-31.4(a)	F 584		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Complaint Intake NJ145778 Based on observations, record reviews, interviews, and facility policy review, it was determined the facility failed to provide a safe environment to prevent resident-to-resident abuse for 5 (Residents #3, #14, #15, #16, and #17) of 5 sampled residents for resident-to-resident abuse. Resident #13 had a diagnosis of NJ Exec. Order 26:4.b.1 and was NJ Exec. Order 26 4.b.1 Residents #3, #14, #15, #16, and #17 were assaulted by Resident #13. Some of the	F 600	Resident #13 is no longer in the facility. Residents #3, #14, #15, #16, and #17 all remain residents in the facility and have had no further incident. There were no other residents affected by this deficient practice All residents are at risk for this alleged deficiency To ensure that this does not reoccur, an education was initiated for all nursing staff including agency, on 8/8/2021 on how to properly perform one to one safety and	8/30/21

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315280	A. BUILDING _____ B. WING _____	C 08/13/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 7 assaults resulted in NJ Exec. Order 26:4.b.1 [redacted] It was determined the facility's non-compliance with one or more requirements of participation caused, or was likely to cause, serious injury, harm, impairment, or death to residents. The Immediate Jeopardy (IJ) was related to State Operations Manual, Appendix PP, §483.12 (Freedom from Abuse, Neglect and Exploitation) at a scope and severity of "J." The IJ began on 07/29/2021 when the resident's physician indicated the resident was NJ Exec. Order 26:4.b.1 [redacted] with other residents. The resident needed NJ Exec. Order 26:4.b.1 [redacted] but the resident remained in the facility. The resident assaulted another resident on 08/08/2021. On 08/08/2021 at 12:00 PM, an IJ was identified. At 5:16 PM, the facility Administrator and Assistant Director of Nurses (ADON) were provided with the completed IJ template and notified of the existence of an IJ for abuse. The Administrator signed the template and returned the original to the survey team. On 08/11/2021 at 1:41 PM, a Removal Plan was accepted by the New Jersey Department of Health (NJDOH). The IJ continued until 08/09/2021 at 10:00 PM, when the facility alleged the elements of the Removal Plan had been implemented. On 08/13/2021 at 9:30 AM, a surveyor conducted	F 600	behavioral observation and was completed on 8/9/2021 by ADON, DON, and ICN. All new agency staff will check in with staffing office to complete education regarding proper one to one observation prior to starting their shift starting 8/9/21. An “At Risk” meeting was conducted to discuss residents at risk for aggressive behaviors on 08/13/2021 and will continue on a weekly basis. Monthly psychotropic meeting was planned on 8/9/21 and conducted 8/26/21 to review medication, medication changes, non-pharmacological behavior interventions, and discuss behaviors. The monthly psychotropic meeting will be resumed on a monthly basis. Any new behaviors that are identified will be discussed, appropriate interventions initiated and the residents Kardex will be updated. To monitor the corrective action: A random audit of one to one performance compliance was implemented on 8/9/2021 and will continue randomly 2 times per week x 6 weeks. The facility will perform audits on the next 5 residents if one to one observation is necessary. Unit Managers and DON/designee will perform these audits. The results of the one to one audits, “at risk” meetings and monthly psychotropic meetings will be reviewed at the facility QA meetings. The Administrator and Director of Nursing/designee will be responsible for this plan of correction and compliance will be achieved by 08/30/2021	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315280	A. BUILDING _____ B. WING _____	C 08/13/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 8	F 600		

an onsite revisit to verify the Removal Plan had been implemented. Resident #13 had been removed from the facility on NJ Exec. Order 26 4.b.1. The facility implemented the Removal Plan, which included education for certified nursing assistants (CNAs), nursing assistants (NAs), and licensed nursing staff for the Atrium, Court Two, and Pavilion and Vent Units on how to properly monitor residents who were on one-to-one behavior monitoring. CNAs, NAs, and licensed staff were being educated on staying within arm's reach of a resident, never leaving a resident alone, ensuring that the one-to-one was covered by another staff member when going to break, and documenting whereabouts and behaviors.

The facility had an updated seating chart of the Pavilion Unit to include any resident on one-to-one will have a seating plan during meals and recreational activities to lessen the chance of another resident being harmed by impulsive behaviors. The facility will continue with the current psychiatry group for continuity of care.

The noncompliance remained on 08/13/2021 for "no actual harm with the potential for more than minimal harm that is not immediate jeopardy" based on the following: The facility had not implemented all areas of the Removal Plan that included the "at-risk" weekly meeting to discuss behaviors, care plans, and possibly new interventions, and the monthly psychotropic meetings with psychiatrists, Director of Nursing (DON), Assistant Director of Nursing (ADON), and Unit Managers (UMs) to discuss any actual and potential issues which may include medication changes or additional interventions.

Findings included:

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315280	A. BUILDING _____ B. WING _____	C 08/13/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 9 A review of a Facility Reported Event (FRE) sent to the New Jersey Department of Health (NJDOH) on 05/31/2021 revealed the following: Resident #3 was the victim of an unproved assault by Resident #13. The attack resulted in Resident #3 being NJ Exec. Order 26:4.b.1 Resident #13 had diagnoses which included NJ Exec. Order 26:4.b.1 . The admission Minimum Data Set (MDS), dated 04/05/2021, indicated Resident #13 had NJ Exec. Order 26:4.b hich indicated the resident was NJ Exec. Order 26:4.b.1 . The resident was NJ Exec. Order 26:4.b.1 . The resident NJ Exec. Order 26:4.b.1 . The MDS revealed the resident had NJ Exec. Order 26 4.b.1 On 08/06/2021 it was observed Resident #13 resided on a NJ Exec. Order 26:4.b.1 1. A facility incident report dated 04/22/2021, reported by an eyewitness (another resident), indicated Resident #13 had slapped a female resident (Resident #15) across the face, while waiting for dinner in the activity room. Resident #15's statement revealed Resident #13 smacked Resident #15 in the face. Resident #15 had diagnoses which included NJ Exec. Order 26:4.b.1 and the resident NJ Exec. Order 26:4.b.1	F 600		

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315280	A. BUILDING _____ B. WING _____	C 08/13/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600		F 600		

Continued From page 10

NJ Exec. Order 26:4.b.1 .

The report indicated Resident #13 denied the allegation at first then changed the story. The resident stated Resident #15 had touched Resident #13's food so Resident #13 smacked Resident #15. There were no staff witnesses. The report did not state whether Resident #15 received injuries.

The resident's care plan dated 04/22/2021 indicated the resident could NJ Exec. Order 26:4.b.1 The interventions put in place were:
NJ Exec. Order 26:4.b.1
get upset.

The resident's care plan also indicated Resident #13 NJ Exec. Order 26:4.b.1 04/22/2021.

A physician's progress note dated 04/23/2021 issued two new orders: 1. Resident #13 was to be NJ Exec. Order 26:4.b.1 , and 2. NJ Exec. Order 26:4.b.1 checks.

No one-on-one monitoring documentation was provided by the facility after inquiries.

2. A facility incident report dated 04/28/2021 at

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315280	A. BUILDING _____ B. WING _____	C 08/13/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 11	F 600		

4:30 PM revealed both residents were in the dining room when Resident #13 hit Resident #16 in the face. Resident #16 retaliated and started hitting Resident #13 in the face.

Resident #16 had a diagnosis of NJ Exec. Order 26:4.b.1 and was NJ Exec. Order 26:4.b.1.

It was noted Resident #13 had NJ Exec. Order 26:4.b.1 he residents were separated, but later in the same mealtime, Resident #13 tried to hit Resident #16 again. Resident #16 started throwing punches at Resident #13. Both residents were NJ Exec. Order 26:4.b.1 NJ Exec. Order 2, and 911 was called to transfer Resident #13 to a local crisis center. The incident report indicated the resident was NJ Exec. Order 26:4.b.1 (no time given).

The resident's care plan updated on 04/28/2021 revealed additional interventions:
1. NJ Exec. Order 26:4.b.1.

The resident's care plan also indicated Resident #13 NJ Exec. Order 26:4.b.1 on 04/28/2021.

The only new intervention was to place the resident on NJ Exec. Order 26:4.b.1. The report did not report a time frame for NJ Exec. Order 26:4.b.1 to

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315280	A. BUILDING _____ B. WING _____	C 08/13/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 12	F 600		

be conducted. The other interventions had already been recommended.

The incident report for Resident #16 revealed Resident #13 would be NJ Exec. Order 26:4.b.1 when returned to the facility. No NJ Exec. Order 26 4.b.1 was provided by the facility after inquiries.

Per the care plan, NJ Exec. Order 26 4.b.1 was not a new intervention, and no time frame was provided related to how long NJ Exec. Order 26 4.b.1 would be provided. The incident report did not indicate if Resident #13 was still on NJ Exec. Order 26:4.b.1 per a physician order dated 04/23/2021.

A physician's order dated 04/30/2021 indicated Resident #13 was to be placed NJ Exec. Order 26:4.b.1 checks for NJ Exec. Order 26:4.b.1.

3. A facility incident report dated 05/31/2021 at 2:42 PM indicated around 10:00 AM, a nurse went to the activity room to retrieve Resident #13 to escort the resident to the resident's room for NJ Exec. Order 26:4.b.1. The nurse left Resident #13 behind as she left to move the treatment cart to the resident's room. Resident #13 was walking unattended as Resident #3 walked by Resident #13 in the hallway. The nurse heard a sound, turned around and saw that Resident #13 had hit Resident #3 in the face. The attack was unprovoked. The incident report indicated the residents were separated and Resident #3 was NJ Exec. Order 26:4.b.1. Resident #3 was returned to the facility around 2:00 PM.

Resident #13 refused to be transported to the

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315280	A. BUILDING _____ B. WING _____	C 08/13/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 13	F 600		

crisis center. NJ Exec. Order 26:4.b.1 was initiated, per physician order, until evaluated by NJ Exec. Order 26:4.b.1.

No psychiatric consult note was provided by the facility after inquiries. No NJ Exec. Order 26 4.b.1 monitoring documentation was provided by the facility after inquiries.

A nurse's note dated 05/31/2021 at 8:28 PM indicated Resident #3 returned to the facility with NJ Exec. Order 26:4.b.1

Resident #13's care plan revealed the intervention was to place Resident #13 on NJ Exec. Order 26:4.b.1.

This intervention was not new.

A physician's progress note dated 05/31/2021 indicated Resident #13 was to be placed on NJ Exec. Order 26 4.b.1 until cleared by NJ Exec. Order 26:4.b.1

The care plan contained no new interventions.

A nurse's note written by the Director of Nurses (DON) on 07/07/2021 at 3:00 PM indicated Resident #13 was to be placed on NJ Exec. Order 26 4.b.1 checks for NJ Exec. Order 26:4.b.1 behaviors were to be documented every shift.

4. A facility incident report dated 07/13/2021 at 4:30 PM reported Resident #13 was walking past Resident #14 when Resident #13 started hitting Resident #14. The staff separated the residents, but Resident #13 continued to threaten the other

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315280	A. BUILDING _____ B. WING _____	C 08/13/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 14	F 600		

resident. Both residents were sent out to a local crisis center. Neither resident had NJ Exec. Order 26 and they were both placed on NJ Exec. Order 26 4.b.1 when they returned to the facility. The report indicated Resident #14 had NJ Exec. Order 26:4.b.1

No one-on-one monitoring documentation was provided by the facility after inquiries.

Resident #14 had a diagnosis of NJ Exec. Order 26:4.b.1

Resident #13's care plan contained no new interventions.

A physician's order dated 07/15/2021 (no time) indicated Resident #13 was NJ Exec. Order 26:4.b.1 No reports were in the medical record that indicated the resident had been sent to the crisis center.

A physician's order dated 07/29/2021 indicated Resident #13 was to be kept on NJ Exec. Order 26 4.b.1 due to NJ Exec. Order 26:4.b.1 with other residents. The resident needed NJ Exec. Order 26:4.b.1 The resident was NJ Exec. Order 26:4.b.1

The above handwritten physician's order had a large circle drawn around the order, with a large star and a big check mark drawn beside it.

On 08/07/2021 at 9:45 AM, Resident #13 was observed by the surveyor to be seated without NJ Exec. Order 26 4.b.1 in the dining/activities room. There

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315280	A. BUILDING _____ B. WING _____	C 08/13/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 15	F 600		

were other residents seated in the dining/activities room with the resident.

On 08/07/2021 at 12:11 PM, Resident #13 was observed by the surveyor walking in the hallway near the dining/activities room without supervision. It was observed there was no staff member providing NJ Exec. Order 26 4.b.1 .

On 08/08/2021 at 10:00 AM, the Administrator was asked why Resident #13 was not immediately transferred to another facility when the physician wrote an order (on 07/29/2021) to NJ Exec. Order 26:4.b.1 He stated the physician spoke with him on 07/29/2021 and did not express to him the resident needed to be NJ Exec. Order 26:4.b.1 . The Administrator stated he contacted a sister facility the following day (07/30/2021) and arranged for the resident to NJ Exec. Order 26:4.b.1]. On Thursday of the following week (08/05/2021), the family refused to allow the resident to be transferred. He stated the resident had a NJ Exec. Order 26:4.b.1 , which made it more difficult to find placement for the resident.

The Administrator stated he had not made any additional arrangements to transfer the resident out of the unit. The Administrator was asked why the resident was not transferred to the facility's behavior unit. He stated he had tried but the physician in charge of the unit would not accept the resident. He added he thought the physician had said the resident needed two diagnoses, and he would not accept him. The Administrator stated he did not remember when he spoke with the physician at the behavior unit. He said when

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315280	A. BUILDING _____ B. WING _____	C 08/13/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 16	F 600		

the resident was NJ Exec. Order 26:4.b.1 Then they send the resident back to the facility, and the facility is required to take the resident back.

The Administrator was asked to provide documentation of attempts to provide placement for the resident. He stated everything was verbal. There was no documentation of anything.

A facility incident report dated 08/08/2021 at 11:10 AM revealed Resident #13 repeatedly hit Resident #17 on the right side of the face. This episode occurred in the activities/dining room. Resident #13 was observed to stand up, approach Resident #17 and start punching Resident #17 in the face. Resident #13 was transferred to NJ Exec. Order 26:4.b.1 Resident #17 was transferred to a local hospital for evaluation and treatment. The incident report revealed Certified Nurse Aide (CNA) #6 (who was assigned to provide NJ Exec. Order 26 4.b.1) provided a written statement which indicated she was not with Resident #13 when Resident #13 started hitting Resident #17 in the face.

Resident #17 was NJ Exec. Order 26:4.b.1 .

On 08/08/2021 at 11:30 AM, Unit Manager #3 stated CNA #6 had been assigned to provide NJ Exec. Order 26 4.b.1 for Resident #13.

During the survey, multiple attempts were made to reach CNA #6. On 08/20/2021 at 1:00 PM, two more attempts were made to contact CNA #6. Multiple attempts had been made to contact the CNA. It sounded as though the call was hung up

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315280	A. BUILDING _____ B. WING _____	C 08/13/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 17 on. On 08/08/2021 at 4:15 PM, Resident #17 had returned from the hospital and was observed sitting in the dining/activity room. The NJ Exec. Order 26:4.b.1 [redacted] On 08/09/2021 at 10:00 AM, three CNAs (CNAs #1, #7, and #8) who provided direct care for Resident #13 stated the resident was unpredictable. There was no way to predict what would set the resident off. If another resident got too close, the resident would jump up and hit the other resident. If a resident walked by, the resident would strike out and hit the other resident. Resident #13 did not like for other residents to be near. Sometimes Resident #13 just did not like the way another resident looked at the resident. Resident #13 was very fast. On 08/09/2021 at 11:20 AM, Resident #13's physician was contacted by phone. He stated he was on vacation, he didn't have the medical record with him, and he didn't remember anything. On 08/09/2021 at 2:00 PM, the Administrator and the DON (Director of Nurses) both verbalized the physician's order did not indicate the transfer needed to be immediate. They added the physician had spoken with each of them, and he did not tell them to transfer the resident immediately. They were asked if there was documentation of NJ Exec. Order 26:4.b.1 for Resident #13, such as NJ Exec. Order 26 4.b.1. They stated they did not have a form that recorded NJ Exec. Order 26 4.b.1, but the resident was always on	F 600		

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315280	A. BUILDING _____ B. WING _____	C 08/13/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 18	F 600		

NJ Exec. Order 26 4.b.1. They were asked if interventions had been reviewed, and if new interventions had been put in place after every altercation. They stated the resident was always on NJ Exec. Order 26 4.b.1.

On 08/20/2021 at 2:15 PM, the resident's physician stated he had recommended Resident #13 be NJ Exec. Order 26:4.b.1

The physician added the resident had been to a crisis center multiple times and that was not effective. The facility had been unable to prevent assaults on other residents by placing the resident on one on one. The physician stated he had discussed medication changes with the resident and a family member, and they had refused, because they felt the resident did not need medications. The physician stated since everything had failed the resident needed to be transferred out as quickly as possible, immediately if possible.

The physician stated he had inquired about placement in the facility behavior unit downstairs. He stated he was told there were insurance issue, and the resident did not qualify.

The physician stated he did speak with the Administrator, DON, and the social worker. He stated he verbalized the resident needed to be transferred quickly, because NJ Exec. Order 26:4.b.1 He stated his job was to make recommendations, it was up to the facility to decide how to handle them.

The facility's abuse policy, updated 05/17/2021, indicated:
"POLICY
1. Residents of Silver Healthcare Center have the

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315280	A. BUILDING _____ B. WING _____	C 08/13/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 19	F 600		

right to be free from abuse, neglect, misappropriation of resident property, corporal punishment, and involuntary seclusion in accordance with State and Federal regulations.
2. Silver Healthcare Center will not condone any form of resident abuse and will continually monitor our facility's policies, procedures, training programs, systems, etc., to assist in preventing resident abuse.
3. All alleged or suspected incidents of abuse, neglect, mistreatment, or misappropriation of residents' property will be thoroughly investigated, and findings documented in a report format.
4. Any case in which abuse, neglect, mistreatment, or misappropriation of residents' property has been suspected will be reported in accordance with State and Federal regulations.
DEFINITIONS
ABUSE:
The infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish. This also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, or psychological well-being. This presumes that instances of abuse of all residents, even those in a coma, cause physical harm or pain or mental anguish ...."

There was no facility policy on one-to-one monitoring.

On 08/11/2021 at 1:41 PM, a Removal Plan was received and accepted by the NJDOH.

Removal Plan:

"Resident #13 is no longer in the building and has

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315280	A. BUILDING _____ B. WING _____	C 08/13/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 20	F 600		

been out of the building since NJ Exec. Order 2. The likelihood for serious harm no longer exists as of 8/09/21 by 10:00pm.

Resident #13 was sent to emergency department for NJ Exec. Order 26:4.b.1 .
Resident #13 will not be returning to Silver Healthcare Center.
The facility currently has one resident on one to one observation because he is a fall risk and has poor safety awareness.

Residents at risk for safety compromising behavior will be audited and their care plans will be updated if appropriate on 8/09/21 by 10:00PM.

The facility started education for CNAs, NAs, and licensed nursing staff for the Atrium, Court two , Pavilion and vent unit on how to properly monitor residents who are on one to one behavior monitoring. CNAs, NAs, and license staff are being educated on staying within arm's reach of the resident, never leaving a resident alone, ensuring that the one to one is covered by another staff member when going to break, and document whereabouts and behaviors. This education was initiated on 8/8/21 and will be completed by 8/9/2021 by 10:00 PM.

Behaviors will be discussed, care planned, and new interventions initiated weekly during "at risk" meetings. The attendees of these meeting are the Medical Director, social workers, DON, IP, ADON, Dietician, and Unit Managers.

Clinical Interdisciplinary team (IDT) attending the "at risk" meetings will relay the outcome through kardex via point click care when care plans are updated with new or revised interventions to the

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315280	A. BUILDING _____ B. WING _____	C 08/13/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 21	F 600		

floor nurses, NAs, and CNAs. Communication will also take place verbally and may even be written as orders or in-services when appropriate.

Monthly psychotropic meetings with psychiatrists, DON, ADON, and Unit Managers to discuss any actual and potential issues which may include medication changes or additional interventions.

Any resident displaying aggressive or other behaviors that may be detrimental to others will have an arranged seating plan during meals and recreational activities. Any resident on one to one will also have a seating plan during meals and recreational activities to lessen the chance of another resident being harmed by impulsive behaviors. We will continue with the current psychiatry group for continuity of care.

Admissions will communicate with Administrator, DON, ADON and Unit Managers to determine whether the facility can properly care for residents with behaviors.

Residents with history of aggression who are deemed a danger to other residents and staff, who are no longer appropriate for SNF placement will be sent to crisis for further evaluation immediately. If the psychiatrist still feels that the resident is a danger to others, then the facility will not be accepting the resident back."

On 08/13/2021 at 9:30 AM, a surveyor conducted an onsite revisit to verify the Removal Plan had been implemented. Resident #13 had been removed from the facility on NJ Exec. Order 26 4.b.1. The facility implemented the Removal Plan, which included education for certified nursing assistants (CNAs), nursing assistants (NAs), and licensed

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315280	A. BUILDING _____ B. WING _____	C 08/13/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 22 nursing staff for the Atrium, Court Two, and Pavilion and Vent Units on how to properly monitor residents who were on one-to-one behavior monitoring. CNAs, NAs, and licensed staff were being educated on staying within arm's reach of a resident, never leaving a resident alone, ensuring that the one-to-one was covered by another staff member when going to break, and documenting whereabouts and behaviors. The facility had an updated seating chart of the Pavilion Unit to include any resident on one-to-one will have a seating plan during meals and recreational activities to lessen the chance of another resident being harmed by impulsive behaviors. The facility will continue with the current psychiatry group for continuity of care. The noncompliance remained on 08/13/2021 for "no actual harm with the potential for more than minimal harm that is not immediate jeopardy" based on the following: The facility had not implemented all areas of the Removal Plan that included the "at-risk" weekly meeting to discuss behaviors, care plans, and possibly new interventions, and the monthly psychotropic meetings with psychiatrists, Director of Nursing (DON), Assistant Director of Nursing (ADON), and Unit Managers (UMs) to discuss any actual and potential issues which may include medication changes or additional interventions.	F 600		
F 689 SS=H	New Jersey Administrative Code § 4.1 (a)(5) Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that -	F 689		8/30/21

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315280	A. BUILDING _____ B. WING _____	C 08/13/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 23 §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: Complaint Intake: NJ145778 Based on observations, record review, and interviews, it was determined the facility failed to provide supervision to prevent resident-to-resident altercations for 5 (#3, #14, 15, 16, 17, and #19) of 5 residents whose records were reviewed for resident-to-resident abuse. This had the potential to affect all residents who resided in the facility. Findings included: A review of a Facility Reported Event (FRE) sent to the New Jersey Department of Health (NJDOH) on 05/31/2021 revealed the following: Resident #3 was the victim of an unproved assault by Resident #13. The attack resulted in Resident #3 NJ Exec. Order 26:4.b.1 Resident #13 had diagnoses which included NJ Exec. Order 26:4.b.1 . The admission Minimum Data Set (MDS), dated 04/05/2021, indicated Resident #13 had NJ Exec. Order 26:4.b he resident was NJ Exec. Order 26:4.b.1 ,	F 689	Resident #13 is no longer in the facility. Residents #3, #14, #15, #16, #17 and #19 all remain residents in the facility and have had no further incidents. There is currently no resident in the building on 1:1 supervision as of 08/27/2021. No other residents were affected. All residents have the potential to be effected by this deficient practice. To ensure that this does not reoccur, an education was initiated for all nursing staff including agency, on 8/8/2021 on how to properly perform one to one safety and behavioral observation based off our updated one to one policy on 08/09/2021 and was completed on 8/9/2021 by ADON, DON, and ICN. All new agency staff will check in with staffing office to complete education regarding proper one to one observation prior to starting their shift starting 8/9/21. To monitor the corrective action: DON/designee performed random audits on each shift to ensure proper 1:1 supervision when a resident is 1:1 supervision. To ensure that one to one is taking place properly, the DON, ADON, and Unit Managers will be reviewing these audits at the facility QA meetings for the next 2 quarters.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315280	A. BUILDING _____ B. WING _____	C 08/13/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 24 NJ Exec. Order 26:4.b.1 . The resident required NJ Exec. Order 26:4.b.1 The MDS revealed the resident had NJ Exec. Order 26:4.b.1 On 08/06/2021 it was observed Resident #13 resided NJ Exec. Order 26:4.b.1 1. A facility incident report dated 04/22/2021, reported by an eyewitness (another resident), indicated Resident #13 had slapped a female resident (Resident #15) across the face, while waiting for dinner in the activity room. Resident #15's statement revealed Resident #13 smacked Resident #15 in the face. Resident #15 had diagnoses which included NJ Exec. Order 26:4.b.1 and the resident NJ Exec. Order 26:4.b.1 The report indicated Resident #13 denied the allegation at first then changed the story. The resident stated Resident #15 had touched Resident #13's food so Resident #13 smacked Resident #15. There were no staff witnesses. The report did not state whether Resident #15 received injuries. The resident's care plan dated 04/22/2021 indicated the resident could become aggressive toward staff and other residents. The interventions put in place were: 1. NJ Exec. Order 26:4.b.1	F 689	The Administrator and Director of Nursing/designee will be responsible for this plan of correction substantial compliance by 08/30/2021.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315280	A. BUILDING _____ B. WING _____	C 08/13/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 25	F 689		

NJ Exec. Order 26:4.b.1

The resident's care plan also indicated Resident #13 NJ Exec. Order 26:4.b.1

A physician's progress note dated 04/23/2021 issued two new orders: 1. Resident #13 was to be NJ Exec. Order 26:4.b.1, and 2. NJ Exec. Order 26:4.b.1 checks.

2. A facility incident report dated 04/28/2021 at 4:30 PM revealed both residents were in the dining room when Resident #13 hit Resident #16 in the face. Resident #16 retaliated and started hitting Resident #13 in the face.

Resident #16 had a diagnosis of NJ Exec. Order 26:4.b.1 and was NJ Exec. Order 26:4.b.1.

It was noted Resident #13 had NJ Exec. Order 26:4.b.1 The residents were separated, but later in the same mealtime, Resident #13 tried to hit Resident #16 again. Resident #16 started throwing punches at Resident #13. Both residents were placed on NJ Exec. Order 2, and 911 was called to transfer Resident #13 to a local crisis center. The incident report indicated the resident was held at the crisis center but returned to the facility later in the night (no time given).

The resident's care plan updated on 04/28/2021 revealed additional interventions:

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315280	A. BUILDING _____ B. WING _____	C 08/13/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 26	F 689		

1. NJ Exec. Order 26:4.b.1 [redacted].

The resident's care plan also indicated Resident #13 initiated acts of physical aggression on 04/28/2021.

The only new intervention was to place the resident on NJ Exec. Order 26:4.b.1. The report did not report a time frame for NJ Exec. Order 26:4.b.1 to be conducted. The other interventions had already been recommended.

The incident report for Resident #16 revealed Resident #13 would be placed NJ Exec. Order 26:4.b.1 when returned to the facility.

One-on-one was not a new intervention, and no time frame was provided related to how long one-on-one would be provided. The incident report did not indicate if Resident #13 was still on NJ Exec. Order 26:4.b.1 per a physician order dated 04/23/2021.

A physician's order dated 04/30/2021 indicated Resident #13 was to be placed on NJ Exec. Order 26 4.b.1 checks for NJ Exec. Order 26:4.b.1.

3. A facility incident report dated 05/31/2021 at 2:42 PM indicated around 10:00 AM, a nurse went to the activity room to retrieve Resident #13 to escort the resident to the resident's room for

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315280	A. BUILDING _____ B. WING _____	C 08/13/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 27	F 689		

NJ Exec. Order 26 treatment. The nurse left Resident #13 behind as she left to move the treatment cart to the resident's room. Resident #13 was walking unattended as Resident #3 walked by Resident #13 in the hallway. The nurse heard a sound, turned around and saw that Resident #13 had hit Resident #3 in the face. The attack was unprovoked. The incident report indicated the residents were separated and Resident #3 was NJ Exec. Order 26:4.b.1 . Resident #3 was returned to the facility around 2:00 PM.

Resident #13 refused to be transported to the crisis center. One-on-one observation was initiated, per physician order, until evaluated by psychiatric consult.

A nurse's note dated 05/31/2021 at 8:28 PM indicated Resident #3 returned to the facility with NJ Exec. Order 26:4.b.1

Resident #13's care plan revealed the intervention was to place Resident #13 on NJ Exec. Order 26 4.b.1 until NJ Exec. Order 26:4.b.1 .

This intervention was not new.

A physician's progress note dated 05/31/2021 indicated Resident #13 was to be placed on NJ Exec. Order 26:4.b.1 e until NJ Exec. Order 26:4.b.1

The care plan contained no new interventions.

A nurse's note written by the Director of Nurses (DON) on 07/07/2021 at 3:00 PM indicated

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315280	A. BUILDING _____ B. WING _____	C 08/13/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 28	F 689		

Resident #13 was to be placed on NJ Exec. Order 26 4.b.1 checks for 72 hours for NJ Exec. Order 26:4.b.1 were to be documented every shift.

4. A facility incident report dated 07/13/2021 at 4:30 PM reported Resident #13 was walking past Resident #14 when Resident #13 started hitting Resident #14. The staff separated the residents, but Resident #13 continued to threaten the other resident. Both residents were sent out to a local crisis center. Neither resident had NJ Exec. Order 26 and they were both placed on NJ Exec. Order 26:4.b.1 e when they returned to the facility. The report indicated Resident #14 had NJ Exec. Order 26:4.b.1

Resident #14 had a diagnosis of NJ Exec. Order 26:4.b.1 and was NJ Exec. Order 26:4.b.1

Resident #13's care plan contained no new interventions.

A physician's order dated 07/15/2021 (no time) indicated Resident #13 was NJ Exec. Order 26:4.b.1

A physician's order dated 07/29/2021 indicated Resident #13 was to be kept on NJ Exec. Order 26:4.b.1 e due to NJ Exec. Order 26:4.b.1 other residents. The resident needed NJ Exec. Order 26:4.b.1 he resident was NJ Exec. Order 26:4.b.1 at this skilled nursing facility (SNF). A social worker should work with the family for placement.

The above handwritten physician's order had a large circle drawn around the order, with a large

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315280	A. BUILDING _____ B. WING _____	C 08/13/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 29	F 689		

star and a big check mark drawn beside it.

On 08/07/2021 at 9:45 AM, Resident #13 was observed to be seated without one-on-one in the dining/activities room. There were other residents seated in the dining/activities room with the resident.

On 08/07/2021 at 12:11 PM, Resident #13 was observed walking in the hallway near the dining/activities room without supervision. It was observed there was no staff member providing one-on-one.

On 08/08/2021 at 10:00 AM, the Administrator was asked why Resident #13 was not immediately transferred to another facility when the physician wrote an order (on 07/29/2021) to NJ Exec. Order 26:4.b.1 He stated the physician spoke with him on 07/29/2021 and did not express to him the resident needed to be transferred out immediately. The Administrator stated he contacted a sister facility the following day (07/30/2021) and arranged for the resident to be transferred to [named facility]. On Thursday of the following week (08/05/2021), the family refused to allow the resident to be transferred. He stated the resident had a NJ Exec. Order 26:4.b.1, which made it more difficult to find placement for the resident.

The Administrator stated he had not made any additional arrangements to transfer the resident out of the unit. The Administrator was asked why the resident was not transferred to the facility's behavior unit. He stated he had tried but the physician in charge of the unit would not accept

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315280	A. BUILDING _____ B. WING _____	C 08/13/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 30	F 689		

the resident. He added he thought the physician had said the resident needed two diagnoses, and he would not accept him. The Administrator stated he did not remember when he spoke with the physician at the behavior unit. He said when the resident was sent out to the crisis center, the center only kept the resident a few hours. Then they send the resident back to the facility, and the facility is required to take the resident back.

The Administrator was asked to provide documentation of attempts to provide placement for the resident. He stated everything was verbal. There was no documentation of anything.

A facility incident report dated 08/08/2021 at 11:10 AM revealed Resident #13 repeatedly hit Resident #17 on the right side of the face. This episode occurred in the activities/dining room. Resident #13 was observed to stand up, approach Resident #17 and start punching Resident #17 in the face. Resident #13 was transferred to a local crisis center at a local hospital. Resident #17 was transferred to a local hospital for evaluation and treatment. The incident report revealed Certified Nurse Aide (CNA) #6 (who was assigned to provide one-on-one) provided a written statement which indicated she was not with Resident #13 when Resident #13 started hitting Resident #17 in the face.

Resident #17 was NJ Exec. Order 26:4.b.1 .

A facility incident report dated 08/08/2021 at 11:10 AM reported CNA #6 provided a written statement which indicated she was not with Resident #13 when Resident #13 started hitting

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315280	A. BUILDING _____ B. WING _____	C 08/13/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 31	F 689		

Resident #17 in the face.

On 08/08/2021 at 11:30 AM, Unit Manager #3 stated CNA #6 had been assigned to provide one-on-one for Resident #13.

On 08/08/2021 at 4:15 PM, Resident #17 had returned from the hospital and was observed sitting in the dining/activity room. The NJ Exec. Order 26:4.b.1 [redacted]

On 08/09/2021 at 10:00 AM, three CNAs (CNAs #1, #7, and #8) who provided direct care for Resident #13 stated the resident was unpredictable. There was no way to predict what would set the resident off. If another resident got too close, the resident would jump up and hit the other resident. If a resident walked by, the resident would strike out and hit the other resident. Resident #13 did not like for other residents to be near. Sometimes Resident #13 just did not like the way another resident looked at the resident. Resident #13 was very fast.

On 08/09/2021 at 11:20 AM, Resident #13's physician was contacted by phone. He stated he was on vacation, he didn't have the medical record with him, and he didn't remember anything.

On 08/09/2021 at 2:00 PM, the Administrator and the DON (Director of Nurses) both verbalized the physician's order did not indicate the transfer needed to be immediate. They added the physician had spoken with each of them, and he did not tell them to transfer the resident immediately. They were asked if there was

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315280	A. BUILDING _____ B. WING _____	C 08/13/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 32 documentation of constant supervision for Resident #13, such as one-on-one. They stated they did not have a form that recorded one-on-one, but the resident was NJ Exec. Order 26:4.b.1 [redacted] They were asked if interventions had been reviewed, and if new interventions had been put in place after every altercation. They stated the resident was always on NJ Exec. Order 26 4.b.1 [redacted]. New Jersey Administrative Code § 8:39-5.1(a)	F 689		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any,	F 756		8/30/21

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315280	A. BUILDING _____ B. WING _____	C 08/13/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 33 action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Complaint Intake: NJ145778 Based on observation, record review, and interviews, it was determined the facility failed to follow up on pharmacy recommendations for 1 (Resident #20) of 3 sampled residents whose medication passes were observed. This had the potential to affect all residents who resided in the facility. Findings included: 1. Resident #20 had diagnoses which included NJ Exec. Order 26:4.b.1 . The resident's Minimum Data Set dated 06/27/2021 recorded the resident was NJ Exec. Order 26:4.b.1 equired supervision with activities of daily living. A physician's order dated 05/26/2021 recorded the resident was to be administered NJ Exec. Order 26 4.b.1 a day. On 08/07/2021 at 9:30 AM, Licensed Practical	F 756	Resident #20 was not adversely effected by this deficient practice. All resident have the potential to be effected by this deficient practice. The facility got a stat order that day and continued ordering regularly. To ensure that this does not reoccur pharmacy recommendations will be communicated via email to DON and Unit managers. DON will educate Unit Managers on the process to follow through with recommendations. To monitor the corrective action: DON will keep copies of recommendations and mark as completed when UMs communicate to the MD and the recommendation is verified. DON will audit the recommendations sent by the pharmacy two times a week and will contact MDs for any recommendation that have not been addressed within a week, for 6 weeks. To ensure the facility is communicating properly with the pharmacy we will be reviewing these audits by the QA	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315280	A. BUILDING _____ B. WING _____	C 08/13/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 34 Nurse (LPN) #6 was observed preparing the resident's morning mediations for Resident #20. It was observed NJ Exec. Order 26:4.b. was not on the medication cart. The LPN stated the medication was ordered yesterday but was not on the cart. She stated she would have the pharmacy deliver it immediately. She left the cart to notify the pharmacy. On 08/07/2021 at 9:45 AM, the Assistant Director of Nurses (ADON) was asked if he could find the form that indicated when the medication had been ordered. On 08/07/2021 at 10:30 AM, the ADON provided a pharmacy review form dated 07/24/2021 which indicated the pharmacist had recommended NJ Exec. Order 26:4.b.1, and NJ Exec. Order 26:4.b.1 due to the resident's insurance did not cover NJ Exec. Order 26:4.b.. On 08/07/2021 at 11:00 AM, the ADON provided a physician's order which indicated the resident was to be administered NJ Exec. Order 26:4.b.1 daily. The order stated to restart once the medication was in the facility. The ADON stated the unit manager had only been here a few days and was unaware of the recommendation. He added the former unit manager had not acted on the recommendation and had not informed anyone. The ADON was asked for the facility policy/procedure for making sure staff was aware of new pharmacy recommendations. He stated he wasn't sure there was a policy, but he would look.	F 756	meetings for the next 2 quarters. The Director of Nursing will be responsible for this plan of correction, substantial compliance will be achieved by 08/30/2021.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315280	A. BUILDING _____ B. WING _____	C 08/13/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 35 On 08/07/2021 at 2:30 PM, the ADON stated he had been unable to locate a policy for how to ensure pharmacy recommendations were readably available for the unit manager to review and act upon.| New Jersey Administrative Code § 8:39-29.3(a)(1)	F 756		

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	9/3/2021 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 F0584	Correction	ID Prefix F0600	Correction	ID Prefix F0689	Correction
Reg. # 483.10(i)(1)-(7)	Completed	Reg. # 483.12(a)(1)	Completed	Reg. # 483.25(d)(1)(2)	Completed
LSC	08/30/2021	LSC	08/30/2021	LSC	08/30/2021
ID Prefix F0756	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.45(c)(1)(2)(4)(5)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	08/30/2021	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
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	
8/13/2021	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO