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 _____	03/12/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS STANDARD SURVEY 3/12/2020 CENSUS: 185 SAMPLE SIZE: 35 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.	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 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;	F 584		4/12/20

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

Electronically Signed | 04/03/2020

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 _____	03/12/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 1 §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to maintain a clean and sanitary environment. This deficient practice was identified for the [redacted], 1 of 5 units in the facility, and was evidenced by the following: On 3/5/2020 at 8:25 AM the surveyor observed the following on the [redacted] side of the [redacted]: 1. There was a solarium style room, with no door, in the corner of the unit between resident rooms [redacted] and [redacted]. There were large windows with artificial plants hanging from the ceiling. The room contained three, 3-drawer cabinets, 4 free-standing closets, 2 chairs, and 2 unmade beds with stained blue mattresses. The room had a [redacted]. There was a heavy accumulation of dirt in the corners and at the floor/wall junctures around the room. 2. There was a large day/dining/activities area	F 584	I. 1. 3-drawer cabinet, 4 free-standing closets, 2 chairs and 2 unmade beds were placed in the solarium room from room [redacted] that was under planned cosmetic renovation. On 3/6/20, furniture and beds were placed back to the room [redacted] and soiled mattresses were disposed, beds were carbolized, and new mattresses were in place. In the solarium style room, between rooms [redacted] and [redacted] all corners were scraped and floor was scrubbed and buffed. 2. All loose and missing cove base moldings were replaced and missing wallboard was repaired. Hallway edges around the rooms of [redacted] were scraped, hallway floor was scrubbed and buffed. 3. Floor of the solarium room between rooms [redacted] and [redacted] was scrubbed buffed	

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 _____	03/12/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 2 outside of resident rooms [redacted]. There was loose cove base molding in areas around the room, missing cove base molding next to resident room [redacted], missing cove base molding next to resident room [redacted], missing wallboard next to resident room [redacted], and an accumulation of dirt at the floor/wall junctures. 3. There was a solarium style room, with no door, between resident rooms [redacted] and [redacted]. There was an accumulation of dirt at the floor/wall junctures and in the corners. There was wall damage by the exit doorway that leads to the outside of the building. There was a ceiling tile near the exit door that had a dried brown stain over the entire tile, which was bulging downward. 4. There was a section of the cove base molding lying on the floor next to res room [redacted]. 5. There was a section of wooden molding missing at the ceiling area above resident room [redacted] 6. There were splatters of a dried brown substance on a pillar by the back entrance to the nurse's station. 7. A large ceiling vent above the television on the [redacted] side had a heavy accumulation of dust. 8. The bases on 6 of 6 dining tables were scuffed and had dried food spills and dirt. 9. A blue dining chair had a dried, brown substance on the surface and side of the seat cushion. The surveyor observed this same chair on 3/9/2020 at 9:25 AM, with the spillage still present. 10. The wooden frame under the seat cushion of 2 red dining chairs was dusty. A non-interviewable resident was seated in one of the chairs, eating breakfast. The surveyor observed 2 red chairs on 3/9/2020 at 9:25 AM with the dust still present. A non-interviewable resident was seated in one of the red chairs	F 584	and all corners were scraped. The ceiling tile was replaced. Wall damage by exit doorway was repaired. 4. Section of cove based by the room [redacted] was replaced. 5. Section of missing wooden molding at the ceiling of the room [redacted] was replaced. 6. A pillar by the back entrance to the nurse's station was cleaned. 7. A large ceiling vent above the television on the [redacted] side was dusted and vent cleaned. 8. The bases on 6x6 dining tables were thoroughly cleaned. 9. All dining room chairs were wiped, cleaned and sanitized. 10. All chairs were wiped, cleaned and sanitized. 11. Central bathroom's floor/walls junctures were scraped and floor was mopped. 12. Wallpaper in the room [redacted] was repaired. Toilet paper rod in the bathroom was installed, the trash can was placed in the bathroom. Floor corners were scraped and floor was scrubbed and buffed. 13. Wall damage below the sink in the room [redacted] was fixed. Floor corners were scraped, floor was scrubbed and buffed, trash can placed in the bathroom. Paper towels removed from toilet bowl and cleaned. 14. 4 missing floor tiles in the bathroom were replaced. Damage to the inside of the bathroom door was repaired. Build-up of dirt in the corners was scraped and floor/wall junctures around the room were scraped and cleaned, floor was scrubbed and buffed.	

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 _____	03/12/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 3 being assisted with breakfast by a staff member. 11. There was a build-up of dirt in the corners and at the floor/wall junctures in the [redacted] " room across from resident room [redacted]. There was a brown substance in areas of the grout between the tiles in the shower stall, wet from a shower being given, in the "[redacted] " room across from resident room [redacted]. On 3/10/20 between 8:25 AM and 9:02 AM, the surveyor observed the following: 1. There was loose, torn, and stained wallpaper in resident room [redacted]. There was no toilet paper rod in the bathroom. The roll of toilet paper was sitting on the toilet tank. There was no trash can in the bathroom; there was a pile of used/wet paper towels on the floor under the sink. There was a build-up of dirt in the corners and at the floor/wall junctures around the room. 2. There was wall damage below the sink in resident room [redacted]. There was no trash can in the bathroom. The toilet bowl contained a large amount of paper towels. There was a build-up of dirt in the corners and at the floor/wall junctures around the room. 3. There were 4 missing floor tiles in the bathroom in the resident room [redacted]. There was damage to the inside of the bathroom door. There was a build-up of dirt in the corners and at the floor/wall junctures around the room. 4. The wallpaper was peeling off of the wall below the bathroom sink in resident room [redacted]. There was an accumulation of dust in the bathroom ceiling vent. There was a build-up of dirt in the corners and at the floor/wall junctures around the room. On 3/5/2020 at 8:49 AM, the surveyor observed	F 584	15. Wallpaper in room [redacted] was repaired. Accumulation of dust was dusted and vent cleaned. Build-up of dirt in the corners and at the floor/wall junctures were scraped, scrubbed and buffed. 16.Wall damage of the area between an exit door to the outside and the side of the nurse's station, including a locked "Family Room," "Activities Office," a "Restroom," and vending machine was repaired. Accumulation of dirt at the floor/wall junctures and in the corner were scraped, scrubbed, cleaned and buffed. 17. Build-up of dirt in the corner and at the floor/wall junctures around the day/dining/activities area was scraped, scrubbed, cleaned and buffed. Heavy build-up in the alcove where the chair scale locates was scraped, scrubbed and buffed; the chair scale was wiped, cleaned and sanitized. 18. Heavy accumulation of dust in the ceiling vent outside of room [redacted] was dusted and vent cleaned. 19. All dining/activity tables in the [redacted]-hall were cleaned and sanitized. 20. Heavy accumulation of dust in the ceiling vent in the aquarium-decorated sitting area by the entrance to the unit was dusted and vent cleaned. 21. The island's countertop and around inside in the [redacted]-hall area was cleaned and sanitized. Cabinet doors were readjusted. 22. All housekeeping staff were in-serviced on proper cleaning techniques and diligent completion of assignments. 23. On 3/10/20 ESD started in-servicing all staff on identifying/reporting/recording of all maintenance issues into the	

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 _____	03/12/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 4 an area between an exit door to the outside and the side of the nurse's station. This area included a locked "Family Room," the "Activities Office," a "Restroom," and vending machines. There was wall damage near the floor next to the restroom door. There was an accumulation of dirt at the floor/wall junctures and in the corners. On 3/5/2020 at 8:52 AM, the surveyor interviewed a housekeeping employee who was on the [redacted] side of the unit. When interviewed, the housekeeping employee said there were usually 2 housekeepers on the unit, and they worked 7 AM to 3 PM. The housekeeping employee said there was no one from housekeeping that worked after 3 PM. They were only here one shift. The housekeeping employee also said, "I believe there's a floor tech in the building, though." When asked what the procedure was for cleaning the unit, the housekeeping employee said, "when we get to the unit, we set up the cart, get water, and start with the nurse's station. We empty the trash, wipe counters, and mop the floor. We clean the breakroom for the employees. Then we come out and mop floors in bathrooms and shower rooms, wipe down sink and toilet, and empty trash. Then we start the rooms (the resident rooms), we do about 10 to 12 rooms daily. We empty the trash, wipe down the dressers, wipe the blinds, wipe the windowsills, wipe the sinks and toilets, dust the lights, and sweep and mop the floor." On 3/5/2020 at 9:36 AM, the surveyor observed the [redacted]-side of the unit and observed the following: 1. There was a build-up of dirt in the corners and at the floor/wall junctures around the day/dining/activities area, and a heavy build-up	F 584	maintenance log book. In-service is ongoing. 24. Assigned housekeeper and floor tech who did not complete their assigned cleaning tasks were terminated as a result of ongoing progressive discipline/corrective measures on 3/11/20. II. All residents have the potential to be affected by the same deficient practice. III. Environmental Services Director /Department Heads will continue to complete rounds of assigned rooms to identify/report/record findings related to safe/clean/comfortable/homelike environment into the maintenance log book and will complete the weekly audit check sheets. 2 times per week for 4 weeks then monthly. All staff will be routinely in-serviced on identifying/reporting/recording of all maintenance issues into the maintenance log binder. All housekeeping staff will be re-in-serviced on proper cleaning techniques and importance of completing of their cleaning assignments. IV. ESD/Administrator will continue to conduct random audits of the rooms/common areas, including cleanliness of the furniture through daily rounds. ESD/Department Heads will continue to complete routine rounds of the assigned rooms to identify/report/record findings related to	

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 _____	03/12/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 5 in the alcove where the chair scale was. The base of the chair scale was very dirty in appearance. 2. There was a heavy accumulation of dust in the ceiling vent outside of resident room [redacted]. 3. The bases on 7 of 7 black dining/activity tables were dusty. (The black tables were a different style than the tables on the [redacted] side.) There was one table on the [redacted]-side that was the same style as the [redacted] side tables. The base of this table was scuffed. 4. There was a heavy accumulation of dust in the ceiling vent in the aquarium- decorated sitting area by the entrance to the unit. 5. There was an island area at the side of the A day/dining/activities area. The island was open in the middle with access via a short, gate-style swing door latched closed from the inside. The white countertop around the inside of the island had red and brown stains. The doors on the cabinets did not fit properly and were hanging down. There was a build-up of dirt at the floor/wall junctures inside of the island. There were dried stains on the inside of the swing door. When interviewed on 3/5/2020 at 9:48 AM, an activities staff member said, "we use the island when I cook. I cook and put things on the counter for the residents to eat." On 3/5/2020 at 10:45 AM, the surveyor interviewed the Environmental Service Director (ESD), who said he had started in the position on 1/10/2020. The ESD said before that, the facility had an outside company for housekeeping services. When asked about the [redacted] unit, the ESD said every housekeeping cart had a housekeeping book on it, which directed the housekeepers for what to do on that specific unit.	F 584	safe/clean/comfortable/homelike environment into the maintenance log book and will complete the audit check sheet for each assignment. Audits will be conducted weekly X 4 weeks, then bi-weekly X 4 weeks, then monthly. Results of the audits will be presented to the monthly QAPI meetings for review and revision as deemed appropriate.	

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 _____	03/12/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 6 The ESD said, "for [redacted], the cart would be labeled [redacted], and the book would go with that cart." The ESD said there were 2 housekeeping employees for the [redacted] unit daily, 7 days a week. The ESD said, "I'm in the process of beefing up the housekeeping staff, the previous company was short on staff." The ESD said, "even if someone calls out, I still try to keep 2 in the [redacted] due to what we face over there. Behaviors from the residents, more spills, bathroom issues. When asked about the [redacted] unit, the ESD said, "It's not where I'd like it to be, but we are trying to improve. It's definitely outdated." The surveyor asked the ESD for a copy of the procedure that was on the housekeeping cart in the [redacted], which was provided to the surveyor at 12:14 PM. Upon review, the surveyor observed a one-page "Cleaning Guidelines" sheet which noted the following in its entirety: 1. Fill up a mop bucket with fresh water on the assigned unit. 2. Start Daily Cleaning at Nurses Station at assigned site. 3. Clean the Unit Employee Break Room. 4. Clean Unit Shower Room. 5. Clean Unit Common Bathrooms. 6. As soon as the last Food Cart is off the floor, start cleaning the assigned rooms.	F 584		
F 641 SS=E	NJAC 8:39-31.4(a) 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	F 641		4/3/20

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 _____	03/12/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 7 by: Based on interview and record review, it was determined that the facility failed to complete an accurate Minimum Data Set (MDS), an assessment tool. This was cited at a level E as the deficient practice was identified for 6 of 37 residents. This deficient practice was identified for 6 of 37 residents reviewed (Residents #5, #13, #79, #119, #127, #142), and was evidenced by the following: 1. On 3/4/2020 at 10:03 AM, the surveyor observed Resident #13 in a wheelchair. Both of the resident's [redacted]. When asked, Resident #13 could not [redacted]. The surveyor reviewed the [redacted] Quarterly MDS for Resident #13. The section for Functional Limitation in [redacted] was coded as "1," indicating there was [redacted]. When interviewed on 3/9/2020 at 9:50 AM, the MDS Coordinator acknowledged that Resident #13 had [redacted] Quarterly MDS. 2. The surveyor reviewed the [redacted] significant change MDS for Resident #119 and observed that the resident was coded as [redacted]. During a review of the medical record, the surveyor observed that the resident was not on [redacted] at that time. When interviewed on 3/11/2020 at 10 AM, the MDS Coordinator stated the resident was currently on [redacted]. (The resident was not currently on [redacted].)	F 641	1. Correction MDS's were immediately completed for residents #5, #13, #79, #119, #127, and #142. Resident # 13 was immediately re-evaluated by the MDS Coordinator for proper coding of section G. 1:1 education was given to the MDS Coordinator by the Department Director regarding accuracy of assessments. Resident # 119 MDS was immediately corrected by the MDS Director and 1:1 education given to MDS Director by the Director of Nursing On Section J/O. Resident #5, 79, and 127's MDS were corrected immediately by the MDS director, In addition Education was given to the Unit Manager regarding the Accuracy of MDS section N, An extensive in-service was done by the Director of MDS which included a review of Psychotropics, Drug Class, and a tool given to use as reference of the Top Drug classes of [redacted]. Resident #142 Was Immediately Re-Evaluated by the Social service director for section C of the MDS and documented appropriately in the medical record. The social service director had just started a few days prior to survey and was given education on the facilities assessment and coding procedures for documenting cognitive status (Section C) of the MDS in the electronic medical record. 2. All residents have the potential to be effected by this 3. On 3-11-20 The MDS Director and the Director of Nursing immediately	

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 _____	03/12/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 8 On 3/11/20 at 11:54 AM, the surveyor interviewed the MDS Coordinator again. The MDS Coordinator stated, "We did know she was coming off [redacted] on [redacted], which was the last covered day" and provided the discharge notification from the billing services company, which was signed 1/7/2020. The MDS Coordinator stated, "That was coded incorrectly." 3. The surveyor reviewed the [redacted] quarterly MDS of Resident #5 and observed that the MDS noted the resident did not receive [redacted] medications on any of the reviewed days but was also marked "Yes - [redacted] were received on a routine basis only." When interviewed on 3/9/2020 at 2:38 PM, the MDS Coordinator stated the coding was incorrect because the resident did not receive [redacted] during the review period. 4. The surveyor reviewed the [redacted] quarterly MDS of Resident #79 and observed that it noted the resident did not receive [redacted] medications on any of the reviewed days but was also marked "Yes - [redacted] were received on a routine basis only." When interviewed on 3/9/2020 at 2:38 PM, the MDS Coordinator stated the coding was incorrect because the resident did not receive [redacted] during the review period. 5. The surveyor reviewed the [redacted] quarterly MDS of Resident #127 and observed the resident did not receive [redacted] medications on any of the reviewed days but was also marked "Yes -	F 641	performed an audit on all current residents MDS of sections C,D,N,G,J, and O . No other issues were found. 4. Education was immediately done for Unit Managers and MDS Coordinator who are currently Inputting Section M,N,O. In addition going forward Unit Managers will not be submitting this data directly into the MDS however using a tool which will be first checked by the Director of MDS or the MDS Coordinator before inputting into the MDS Sections M,N,and O. An Audit using the MDS Accuracy Tool, will be performed on 10% of all quarterly assessments which is 170 Total and results in 4 Per week on sections M,N,O,C,D,and J By the Director of Nursing/MDS Director/Administrator. This will result in 17 per week X 4 Weeks then Biweekly x 4 Weeks then Monthly. All Results will be discussed in Clinical and in the Quarterly Quality assurance Meeting attended by the Administrator, Medical Director , Infection Preservationist and Director of Nursing .	

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 _____	03/12/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 9 [redacted] were received on a routine and [as needed] basis." When interviewed on 3/9/2020 at 2:38 PM, the MDS Coordinator stated the coding was incorrect because the resident received an [redacted] medication twice during the review period. 6. On 3/4/2020 at 10:02 AM, the surveyor observed Resident #142 lying in bed. He/she was awake, alert, and answered questions appropriately. The surveyor reviewed the [redacted] quarterly MDS of Resident #142 and observed it did not include the staff's assessment to determine the resident's [redacted]. The MDS also included that the resident did not receive [redacted] medications during the review period, but was also marked "Yes - [redacted] were received." When interviewed on 3/9/2020 at 2:31 PM, the Social Worker stated that she should have completed the Staff Assessment for Mental Status section of the MDS, but she "hit the wrong button" which was "done in error." When interviewed on 3/9/2020 at 2:38 PM, the MDS Coordinator stated the resident did not have any [redacted] medications ordered, and the "coding was incorrect." NJAC 8.39-11.1	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and	F 656		4/12/20

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 _____	03/12/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 10	F 656		

implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(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.
This REQUIREMENT is not met as evidenced

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 _____	03/12/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 11 by: Based on observation, interview, and record review, it was determined that the facility failed to follow the resident's established care plan that was in place to address concerns identified by the interdisciplinary team. This deficient practice was identified for 2 of 35 residents (Residents #7 and #161) whose care plans were reviewed, and was evidenced by the following: 1. Resident #7 had diagnoses that included [redacted]. The annual [redacted] Minimum Data Set, an assessment tool, identified that the resident was [redacted] A 2/21/2020 Annual Nutrition Assessment, completed by the Dietitian, included that the resident's "weight is trending down." The note also included that "resident constantly wandering/ambulating around the unit" and that the weight loss "may also be attributed to deterioration of disease process." The Dietitian also noted that the weight loss was "undesirable" but "not clinically significant." The Dietitian wrote, "weight maintenance is goal." The surveyor reviewed a 3/11/2020 Nutrition Progress Note (PN), written by the Dietitian, that included resident "has good PO (by mouth) intake for fortified foods (super cereal and super mashed potatoes)." The PN also included "Diet: Regular/Mechanical Soft Texture/Thin Liquids +fortified foods at all meals." The surveyor reviewed the resident's care plan and observed that it included a "Focus" of "I am at nutritional risk," and the interventions included	F 656	1. Resident # 7 was re-evaluated by the registered dietitian and continues to require fortified foods, An audit was started on 3-11-20 First on the Kitchen tray line to all residents on fortified foods ensuring that fortified foods were being prepared and given correctly according to current orders/recommendations. RD Performed a Second audit in person during Breakfast and lunch on 3-13-20, and then Lunch and Dinner on 3-16-20, and continues to perform daily and weekly audits to ensure the accuracy of each residents ordered meal. An ADHOC weight meeting initiated by the Director of Nursing was held on 3-17-20 which addressed each residents weight concerns, and re-established goals to ensure residents with weight concerns will be addressed in a proper timely manor 2. All residents on Fortified foods have the potential to be affected by this. 3. Director of Dietary services/Registered Dietitian Completed initial audit of all residents on fortified foods with no new issues found. All care plans were reviewed and corrections made if needed. 4. A Random sample will be selected and audit will be checked by the Dietary Director on the tray Line Director of nursing/Assistant director of nursing on physical trays on the units 2x per week x 4 weeks, then weekly X 6 weeks and then Quarterly. Results will be discussed at the Monthly weight meeting, attended by the Director of Nursing, Assistant Director of Nursing, Rehab, And Unit Managers	

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 _____	03/12/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 12 "provide diet as ordered" and "fortified foods at all meals." On 3/5/2020 at 8:50 AM, the surveyor observed Resident #7 at the breakfast meal. Super cereal was listed on the resident's meal tray ticket. The super cereal was not sent to the resident. On 3/10/2020 at 8:15 AM, the surveyor observed Resident #7 at the breakfast meal. Super cereal was listed on the resident's meal tray ticket. The super cereal was not sent to the resident. On 3/11/2020 at 12:46 PM, the surveyor observed Resident #7 at the noon meal. Super mashed potatoes were listed on the resident's meal tray ticket. The super mashed potatoes were not sent to the resident. 2. The surveyor reviewed the medical record of Resident #161 and observed that the resident had diagnoses that included [redacted]. The [redacted] Minimum Data Set identified that the resident was [redacted]. On 3/4/2020 at 10:07 AM, the surveyor observed Resident #161 lying in bed. An Occupational Therapist (OT) was working with the resident. When interviewed at that time, the OT said she was working with the resident's [redacted]. The surveyor observed a [redacted] in the resident's [redacted]. The surveyor observed that the resident's [redacted]. The surveyor observed the OT using [redacted] that she was getting into the [redacted]	F 656	1. Resident # 161's Current medical record was reviewed and audited by the Unit Manager as well as the occupational therapist who was working with the resident. All Orders were immediatly discontinued and the plan of care corrected and updated to reflect trialing of the [redacted] to ensure the residents comfort. 2. All residents with Devices have the potential to be effected. 3. on 3-16-20 all Residents who currently have [redacted] in place were re-evaluated by therapy, in conjunction with unit managers to ensure that if ordered; are in place ,and appropriate as per current orders on POS, as well as on the plan of care, any items found if any were corrected immediately. All Licenced Nurses and Certified Nursing assistants were RE-Educated on diffrent types of [redacted], placcement, and kardex by therapy and unit managers. 4. The Director of Therapy has initiated a monthly review of all devices in place, trials being done and any changes in orders that may be needed. The unit manager/Assistant Director of nursing will be responsible for ensuring all changes are completed accurately and timely to the POS, and Plan of care. The unit managers/Assistant Director of Nursing will Perform weekly audits on all residents with devices to ensure that what is currently ordered matches the plan of care and physically in place. Audits will be done weekly X 4 weeks then Bi-Weekly X 6 weeks then monthly by the	

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 _____	03/12/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 13 During a review of the medical record, the surveyor observed that the physician signed, 3/2020 Physician's "Order Form" included "7/28/2019 [redacted] for 8 hours as tolerated in the morning" and "10/19/2019 [redacted] in the [redacted] at all times except for hygiene and skin care." The resident's care plan also addressed the use of [redacted] under a "Focus" area of "(Resident) has [redacted]." The "Goal" was "(Resident) will demonstrate increase in [redacted]." On 3/9/2020 at 10:21 AM, the surveyor observed the resident lying in a recliner in the unit day area. There was nothing in either of the resident's [redacted]. On 3/10/2020 at 8:15 AM, the surveyor observed the resident lying in bed. According to the orders, the resident should have had a [redacted]. There was nothing in the resident's [redacted]. On 3/10/2020 at 2:15 PM, two surveyors observed the resident lying in a recliner in the unit day area. There was a [redacted] in the resident's [redacted]. There was nothing in the resident's [redacted]. On 3/11/2020 at 12:30 PM, the surveyor observed the resident lying in a recliner in the	F 656	Unit Manager/Assistant Director of Nursing . All Findings will be reported during Clinical meetings for immediate attention with the interdisciplinary team, and reported to the Quality Assurance committee quarterly, attended by The administrator , Director of Nursing, Infection Preventionist and Medical director.	

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 _____	03/12/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 14 unit day area. There was a [redacted] in the resident's [redacted]. There was nothing in the resident's [redacted]. NJAC 8:39-11.2(d)	F 656		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to follow acceptable standards of clinical practice with medication administration, obtaining physician's orders, and positioning of a resident during a [redacted]. This was cited at a level E as the deficient practice was identified for 3 of 35 residents on 2 of 5 units. This deficient practice was identified for 3 of 35 residents (Residents #109, #127, and #142) reviewed for professional standards, and was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as casefinding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed	F 658	1. Unit manager and Nurse Practitioner immediately evaluated resident #109's current medical records, including Medication administration record, Physician order summary, and Physician Progress notes for the period of 1/5/2020 until current. Resident evaluated for Pain and had a continued need of Medication. A Med error report was completed and the Resident representative, Physician And Pharmacy was notified. Resident had no ill effects of Continued medication. A Script from the Physician was in chart for a 30 day supply. A New Order was written on 3-10-20 for the continued use of the medication for this resident. The licensed nurse/Nurses were given a 1:1 Education, as well as written discipline regarding the signing of Medication Administration record after an order was stopped as well as process of completing the 24 Hour chart check 2.All residents with new orders for	4/12/20

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 _____	03/12/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 15 by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of casefinding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." 1. The surveyor reviewed the medical record of Resident #109 and observed a [redacted] Physician's Order (PO) for [redacted] every 6 hours as needed for pain, re-evaluate in 7 days. There was no corresponding PO for the [redacted] to be administered after 1/11/2020. Upon review of the January 2020 Medication Administration Record (MAR), the surveyor observed that the [redacted] had continued to be administered after 1/11/2020. The resident's "Individual Patient Controlled Substance Administration Record" for the [redacted] from 1/5/2020 through 2/13/2020 included that [redacted] had been administered 107 times after 1/11/2020 until a new order was received on 2/13/2020. During an interview on 3/10/20 at 12:54 PM, the Registered Nurse (RN) in charge of the unit said no reevaluation had been done on 1/11/2020.	F 658	narcotics have the potential to be affected by this deficient practice. All Medication administration records were audited to ensure that all new Medication orders were transcribed according to physician orders. 3.The Assistant director of nursing /In House Nurse practitioner re-educated all nursing staff which is ongoing on order transcription of narcotics medications as well as the Policy and Procedure titled Medication Transcription. The Medical Director will re-educate all physicians, Nurse practitioner & Physicians assistants on ordering new narcotics medications via Phone and 1:1 Education with emphasis on not using "RE-EVAL. 4. Unit Managers will audit new orders for new [redacted] and narcotics medications to assure that a 14 day stop date and a new order is obtained if needed based on the residents assessment by the licensed nurse. Audits will be completed 5 days a week x 2 weeks then weekly x 3 months. The Director of Nursing will report results during the quarterly Quality Assurance meeting which is attended by the Administrator, Director of Nursing, Infection Preventionist, and Medical director. 1. Resident # 127 Was immediately Assessed by the Nurse Practitioner with documentation in the medical record that residents [redacted], Resident continued to be	

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 _____	03/12/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 16 The RN could not find an order for the [redacted] between 1/11/2020 and 2/13/2020, and the RN acknowledged that Resident #109 should not have received [redacted] after the 11th without a physician's order. The surveyor reviewed the facility's "Charting, Transcription of Orders, and Documentation" Policy dated 7/2019 and observed that the policy included "Duration/Stop date: If indicated; EX; "Re-Evaluate in 14 days": Order shall be marked on MAR/TAR to stop and re-evaluate in 14 days which means that a new order shall be received and transcribed to MAR/TAR as a new order, and a new order date shall be transcribed." 2. On 3/10/2020 at 8:17 AM, the surveyor observed the RN administer four medications [redacted] to Resident #127. The resident was lying with [redacted] at the foot of the bed, and the resident's [redacted] was not elevated. When interviewed on 3/10/2020 at 8:55 AM, the RN stated the resident's [redacted] during medication administration. Still, for this resident, it was "impossible because of how [Resident #127] moves in the bed." During an interview on 3/10/2020 at 1:11 PM, the Licensed Practical Nurse (LPN) in charge of the unit stated that during med pass, all residents should have their [redacted] and that it would not be impossible for Resident #127 to be positioned this way. The LPN further stated that it was necessary to properly position residents befor [redacted]	F 658	monitored without any ill effects. Nurse was immediately given 1:1 education, and discipline related to Positioning, preparation, and giving medications safely. Nurse will be followed randomly for Med pass By the Consultant pharmacist as well as the Infection Preventionist when consultant is not present. This will be done monthly x2 months then quarterly x4 quarters. 2. All residents receiving medications [redacted] have the potential to be effected. 3. Unit Manager/Assistant director of nursing Immediately re-educated all licensed nurses on "Medication administration [redacted], Positioning, and evaluation of safety prior to administering medications. All licensed nurses have performed return demonstration. 4. Unit Managers/Nursing Supervisor will Continue to Perform Random medication pass Audits on 2 nurses performing medication administration [redacted] across all shifts, 2 nurses on each shift will be med passed by Nurse Supervisor, Assistant director of nursing, Unit Manager, And or Director of Nursing with emphasis on safety, and proper positioning weekly x 4 weeks, then monthly x 6 weeks, then Quarterly. All findings will be immediately reported to Director of Nursing and then a Summary at the Quarterly Quality assurance Meetings attended by the Administrator,	

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 _____	03/12/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 17 In a meeting with the survey team on 3/12/20 at 9:13 AM, the Director of Nursing stated it is never safe to give medications while the resident is [redacted]. Review of the facility's Medication Administration policy revised 12/2019 included, "Resident to be properly positioned to receive medications [redacted] 3. On 3/4/2020 at 10:02 AM, the surveyor observed Resident #142 lying in bed in a pleasant mood. The surveyor reviewed the resident's medical record and observed a 2/6/2020 physician's order for [redacted] every six hours as needed for [redacted] for 14 days (stop 2/20/2020) then re-evaluate the need for use. The resident's 2/2020 MAR included the [redacted] order with a stop date of 2/20/2020. The surveyor observed that nurses' signatures for the administration of the medication were recorded six times after the stop date. The resident's Controlled Substance Administration Record for [redacted], dated 2/20/2020, noted that the medication was dispensed 12 times after 2/20/2020. During an interview on 3/5/2020 at 10:13 AM, the LPN in charge of the unit looked in the resident's chart and could not find an order for [redacted] between 2/20/2020 and 3/1/2020. At 10:53 AM, the LPN stated the nurses should have received a new order before administering the [redacted]	F 658	Director of Nursing, Infection Preventionist, and Medical Director. 1. Resident # 142 was immediately evaluated by licensed nurse and nurse practitioner, resident 142's Current medical records were audited, previously the resident had been taking the medication and was still in current need. On 3/1/20 The licensed nurse noted this error and called for a one time order for 24 hours, until the practitioner could write a new order. A new order for the medication was received and written on 3/1/2020. Immediate re-education given to all licensed staff regarding transcription and 24 Hr. Chart check. 1:1 Education done with nurses who signed for the medication and a med error form was completed, Family, and physician were notified as well as pharmacy. 2. All residents on newly ordered Antipsychotics have the potential to be affected by this deficient practice. All medication administration records were audited to assure that all new [redacted] orders have been executed correctly. 3.The Assistant Director of Nursing /Nurse Practitioner has given all licensed nurses education on [redacted] monitoring and the 14 day rule, as well as following up with practitioners and order re-evaluation for their residents who were newly started on a [redacted]. the Assistant director of nursing and Nurse practitioner will continue to re-educate all	

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 _____	03/12/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 18 During an interview on 3/5/2020 at 11:33 AM, the Director of Nursing stated there wasn't an order for [redacted] in the resident's chart from 2/20/2020 to 3/1/2020. Review of the facility's "[redacted] Medication Monitoring" policy and procedure dated 9/14/19, included "Initial Dosing of a [as needed] [redacted] will be limited to 14 days" and "The Practitioner will then review and may reorder the medication for a longer duration if warranted." NJAC 8:39-11.2(b) NJAC 8:39-27.1 (a)	F 658	nursing staff on order transcription as well as protocol for initiating and stopping any new [redacted] order , as well as the Policy and Procedure titled Medication Transcription. In Addition on 3-10-20 The in house Nurse practitioner re-educated all physicians via a 1:1 Verbal telephone conversation regarding the importance of, ordering, monitoring, and documenting need of new [redacted] Medication via Phone and an emphasis on not using "RE-EVAL. 4. The Unit Managers/Assistant Director of Nursing will audit new orders for new [redacted] and narcotics medications to assure that a 14 day stop date and a new order is obtained if needed based on the residents assessment by the licensed nurse. Audits will be completed 5 days a week x 2 weeks then weekly x 3 months. The Director of Nursing will report results quarterly during Quality assurance meetings, attended by the Facility administrator, Director of Nursing, Infection Preventionist and The Medical Director.	
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §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	F 688		4/12/20

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 _____	03/12/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 19 §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, and record review, it was determined that the facility failed to provide hand devices that had been ordered to prevent further decline in a resident's [redacted]. This deficient practice was identified for 1 of 2 residents reviewed (Resident #161) for positioning/range of motion and was evidenced by the following: The surveyor reviewed the medical record of Resident #161 and observed that the resident had diagnoses that included [redacted]. The [redacted] Minimum Data Set, an assessment tool, identified that the resident was [redacted]. On 3/4/2020 at 10:07 AM, the surveyor observed Resident #161 lying in bed. An Occupational Therapist (OT) was working with the resident. When interviewed at that time, the OT said she was working with the resident's [redacted] and [redacted]. The surveyor observed a [redacted] in the resident's [redacted]. The surveyor observed that the resident's [redacted]	F 688	1. Resident # 161's Current medical record was reviewed and audited by the Unit Manager as well as the occupational therapist who was working with the resident. All Orders were immediately discontinued and the plan of care corrected and updated to reflect trialing of the [redacted] to ensure the residents comfort. 2. All residents with Devices have the potential to be effected. 3. on 3-16-20 all Residents who currently have [redacted] in place were re-evaluated by therapy, in conjunction with unit managers to ensure that if ordered; they are in place and appropriate as per current orders on Physician order summary , as well as the plan of care, items found if any were corrected immediately. On 3-11-20 All Licenced Nurses and Certified Nursing assistants were RE-Educated on different types of [redacted] and placement, viewing the kardex, and tasks	

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 _____	03/12/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 20 [redacted]. The surveyor observed the OT using that she was getting into the [redacted] During a review of the medical record, the surveyor observed that the Physician signed, 3/2020 Physician's "Order Form" included "7/28/2019 [redacted] for 8 hours as tolerated in the morning" and "10/19/2019 [redacted] in the [redacted] at all times except for hygiene and skin care." The resident's care plan also addressed the use of hand devices under a "Focus" area of "(Resident) has [redacted] and [redacted] appropriately." The "Goal" was "(Resident) will demonstrate [redacted] for 8 hours as tolerated, [redacted]." On 3/6/2020 at 12:41 PM, the surveyor observed the resident lying in a recliner in the unit day area. There was nothing in either of the resident's hands. On 3/9/2020 at 10:21 AM, the surveyor observed the resident lying in a recliner in the unit day area. There was nothing in either of the resident's hands. On 3/10/2020 at 8:15 AM, the surveyor observed the resident lying in bed. According to the orders, the resident should have had a [redacted]. There was nothing in	F 688	in the electronic medical record to ensure that the resident has in place what is ordered. This education is ongoing 4. The Director of Therapy has initiated a monthly review of all devices in place, trials being done and any changes in orders that may be needed. The unit manager/ADON will be responsible for ensuring all changes are completed accurately and timely to the physician order summary, and Plan of care. The unit manager/Assistant Director of nursing will Perform weekly audits on all residents with devices to ensure that what is currently ordered matches the plan of care and physically in place. Audits will be done weekly X 4 weeks then Bi-Weekly X 6 weeks then monthly by the Unit Manager/ADON. All Findings will be reported during Clinical meetings for immediate attention with interdisciplinary team and discussed quarterly at Quality assurance meetings attended by the Administrator, Director of Nursing, Infection Preventionist, and Medical director.	

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 _____	03/12/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 21 the resident's [redacted]. On 3/10/2020 at 2:15 PM, two surveyors observed the resident lying in a recliner in the unit day area. There was a [redacted] in the resident's [redacted]. There was nothing in the resident's [redacted]. On 3/11/2020 at 12:30 PM, the surveyor observed the resident lying in a recliner in the unit day area. There was a [redacted] in the resident's [redacted]. There was nothing in the resident's [redacted] When interviewed at that time, the unit Licensed Practical Nurse (LPN) said she had the resident that day, and nurses put [redacted] on residents. When the surveyor told the nurse, there was nothing in the resident's [redacted]. The LPN said, "ok." The surveyor asked the LPN if she knew what the order was for [redacted]. The LPN said, "I have to look it up," and then went to look at the Treatment Administration Record. The LPN then said, "I haven't done anything with (him/her) today, (he/she) just came out." The LPN said, "I'll go see if there's a [redacted] in (his/her) drawer." The LPN went into the resident's room and took a [redacted]. The LPN said, "I will put it in (his/her) [redacted]." During a follow-up meeting on 3/12/2020 at 9:15 AM, the Director of Nursing confirmed that the resident should have been wearing the [redacted] as ordered on the current Physician's "Order Form" and if the resident had refused, there should have been documentation that he refused. NJAC 8:39-27.1(a)	F 688		

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 _____	03/12/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record	F 690	1. Resident # 62 was immediately	4/12/20

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 _____	03/12/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 23 review, it was determined that the facility failed to maintain an [redacted] according to the facility policy. This was identified for 1 of 5 residents (Resident #62) reviewed for [redacted]. This deficient practice was evidenced by the following: The surveyor reviewed the medical record and observed Resident #62 had diagnoses that included [redacted] The surveyor reviewed the [redacted] Minimum Data Set (MDS), an assessment tool, and observed that the resident was identified as having an [redacted] The MDS also identified Resident #62 as [redacted]. The resident's current care plan, revised 3/10/20, noted that the resident had an [redacted] with interventions that included to position the [redacted] below the level of the [redacted] at all times and monitor for signs of [redacted]. The 2/10/20 Physician's Orders included an order for [redacted] every shift. On 3/4/20 at 9:55 AM, the surveyor observed the resident asleep in bed. The [redacted] and [redacted] was partially hanging out of the [redacted] and was touching the floor. The [redacted] was on the door side of the resident's bed and could be observed from the doorway. In addition, the resident's room had a strong smell of urine.	F 690	assessed by the infection Preventionist to assure that resident was in no distress, in addition the [redacted] was appropriately in position and the resident had a continued need for an [redacted]. Resident # 62's [redacted] was returned to [redacted] and a new [redacted] was ordered for this resident as well as like residents with a [redacted]. A new special type of [redacted] was ordered and initiated with a [redacted] which is [redacted] to assure dignity at all times. 2. All residents with [redacted] have the potential to be affected by this practice 3. All Nursing staff were Re-Educated on Ensuring [redacted] are covered at all times and Re-Education received regarding the assurance of dignity to each resident. The Infection Preventionist performed an audit on 3-12-20 on all residents with [redacted], this will be ongoing. 4. The Infection Preventionist/Assistant director of nursing will Perform [redacted] Audits 2 X per week X 4 Weeks and turn into the Director of nursing, then 1X Per week x 6 weeks, then monthly. All findings will be reviewed during the Monthly Infection control Meeting/ and quarterly Quality Assurance meetings attended by the Administrator, Director of Nursing, Infection Preventionist, and Medical director.	

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 _____	03/12/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 24 On 3/5/20 at 8:33 AM, the surveyor observed the resident's [redacted] and [redacted] lying on the floor on the door side of the bed. During a further review of the medical record, the surveyor observed that the resident had been diagnosed with a [redacted] and was treated with the [redacted] two times a day for 7 days and [redacted] daily for 10 days. On 3/5/20 at 12:40 PM, the surveyor observed the resident in bed with the [redacted] hanging on the side of the bed by the door. The [redacted] was partially out of the [redacted], not touching the floor, but could be seen from the doorway with [redacted] visible. On 3/5/20 at 1:08 PM, the surveyor observed the [redacted] hanging from the side of the bed (doorway side), halfway out of the [redacted]. The [redacted] could be observed from the hallway, and [redacted]. On 3/6/20 at 9:25 AM, the surveyor observed the resident's [redacted] from the side rail of the bed with the [redacted] and [redacted] touching the floor. On 3/6/20 at 10:42 AM, the surveyor observed Resident #62's [redacted] still touching the floor from the earlier observation. The [redacted] was hanging partially out of the [redacted] The [redacted] was visible from the doorway.	F 690		

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 _____	03/12/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 25 On 3/6/20 at 1:09 PM, the surveyor observed the resident's spouse visiting the resident and stepping on the [redacted], which was lying on the floor next to the bed. On 3/9/20 at 9:31 AM, the surveyor observed the [redacted] on the floor. On 3/9/20 at 9:40 AM, the surveyor interviewed the Registered Nurse (RN) and the Certified Nursing Assistant (CNA) responsible for the resident's care. The RN stated, "I hooked it up to the bed this morning at about 9:15 AM. It must have fell [sic] off the bed from the resident moving." The CNA stated, "Sometimes they don't hook it to the bed right, and it falls off. The RN hooked it up to the bed today." The CNA stated he usually [redacted] and hooked it back to the side of the resident's bed. On 3/9/20 at 12:45 PM, the Administrator provided the surveyor with the facility policy "Policy and Procedures: [redacted]" with revision date 10/4/19." The policy included the following: "[redacted] The [redacted] should be kept from [redacted], and the [redacted] should always be kept below the [redacted]." And "Hang the [redacted] below the level of the [redacted] which can cause [redacted]. [redacted] should not drag on the floor or be lower than the [redacted]." NJAC 8:39-19:4(a)(1-6)	F 690		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes,	F 692		4/2/20

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 _____	03/12/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 692	Continued From page 26 both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to provide a resident with nutritional interventions that were recommended for a resident with nutritional concerns. This deficient practice was identified for 1 of 5 residents (Resident #7) who were reviewed for nutrition and was evidenced by the following: Resident #7 had diagnoses that included [redacted]. The annual [redacted] Minimum Data Set, an assessment tool, identified that the resident was [redacted]	F 692	1. Resident # 7 was re-evaluated by the registered dietitian and continues to require fortified foods, An audit was started on 3-11-20 First on the Kitchen tray line to all residents on fortified foods ensuring that fortified foods were being prepared and given correctly according to current orders/recommendations. Registered dietition Performed a Second audit in person during Breakfast and lunch on 3-13-20, and then Lunch and Dinner on 3-16-20, and continues to perform daily and weekly audits to ensure the accuracy of each residents ordered meal, Consistency, and equipment if any. An ADHOC weight meeting initiated by the Director of nursing was held on 3-17-20 which addressed each residents	

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 _____	03/12/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 692	Continued From page 27 A 2/21/2020 Annual Nutrition Assessment, completed by the Dietitian, included that the resident's "weight is trending down." The note also included that "resident constantly wandering/ambulating around the unit" and that the weight loss "may also be attributed to deterioration of disease process." The Dietitian also noted that the weight loss was "undesirable" but "not clinically significant." The Dietitian wrote, "weight maintenance is goal." The surveyor reviewed a 3/11/2020 Nutrition Progress Note (PN), written by the Dietitian, that included resident "has good PO (by mouth) intake for fortified foods (super cereal and super mashed potatoes)." The PN also included "Diet: Regular/Mechanical Soft Texture/Thin Liquids +fortified foods at all meals" and that the resident "mostly" ate 51 to 100%." The surveyor reviewed the resident's care plan and observed that it included a "Focus" of "I am at nutritional risk," and the interventions included "provide diet as ordered" and "fortified foods at all meals." On 3/5/2020 at 8:50 AM, the surveyor observed Resident #7 at the breakfast meal. The resident was sitting at a dining table, and feeding self scrambled eggs. The resident ate all of the eggs, drank all of the 8 oz whole milk, orange juice, and 8 oz coffee. A Certified Nursing Assistant (CNA) was sitting with the resident and got more orange juice, which the resident also drank all of. There was a piece of toast on the plate which the resident also ate. The meal tray slip noted that the resident was to receive butter, but none had come on the tray. When interviewed at that time, the CNA said no one on the unit had received	F 692	weight concerns, and re-established goals with Registered dietitian to ensure residents with weight concerns will be addressed in a proper timely manor ,as such Registered dietitian is to Perform in person Meal Monitoring on all residents with weight concerns at least one meal daily. 2. All residents on Fortified foods have the potential to be affected by this. 3. Director of Dietary services/Registered dietitian Completed initial audit of all residents on fortified foods ensuring that what was ordered matched trays with no new issues found. 4. Random spot audits will be checked by the Dietary Director on the tray line and the Registered dietitian/Infection preventionist/Director of nursing/Assistant director of nursing on physical trays on the units at least one meal daily on 10% of residents with Weight loss and fortified foods, and 2x per week x 4 weeks, for 10% of the resident population for non weight loss then weekly X 6 weeks and then Quarterly. Results will be discussed at the Monthly weight meeting and reported to the QAPI committee quarterly, Attended by the Administrator, Director of Nursing, Medical Director, and Infection Preventionist	

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 _____	03/12/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 692	Continued From page 28	F 692		

butter that morning. (The surveyor was told that the kitchen was out of butter in a subsequent interview with the Food Service Director (FSD) on 3/5/2020 at 9:40 AM and that no one had received butter that morning.) When interviewed during the breakfast meal observation, the CNA said the resident "will sit long enough to eat and will eat everything, always does, either by self or with our help." The CNA said, " I always let (Resident #7) feed themselves for as long as (Resident #7) will do it."

The surveyor also observed that the meal tray slip included "super cereal," which the resident did not receive. When the surveyor told the Licensed Practical Nurse (LPN) that there was no super cereal, the LPN said she would call the kitchen. A few minutes later, the surveyor observed the CNA feeding the resident Rice Krispies. When the surveyor mentioned to the CNA that the meal tray slip said super cereal, the CNA asked the surveyor what super cereal was. The surveyor told the CNA that super cereal was a fortified cereal that usually looked like oatmeal. The surveyor went back to the LPN and asked if she had called the kitchen. The LPN said, "yes." The surveyor then asked the LPN what she specifically had asked for, and the LPN said, "super cereal." When the surveyor told the LPN that the kitchen had sent Rice Krispies, the LPN said the resident would eat the Rice Krispies. The surveyor mentioned to the LPN that the resident was supposed to have super cereal. The LPN then asked the surveyor what super cereal was. The surveyor told the LPN that it was a fortified cereal. The LPN said she would call the kitchen again. (The resident did eat all of the Rice Krispies with milk in it.)

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 _____	03/12/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 692	Continued From page 29	F 692		

On 3/5/2020 at 9:40 AM, the FSD approached the surveyor on the nursing unit with a cereal bowl in hand. The FSD said he had brought super cereal and said, "they probably brought regular oatmeal before." The surveyor told the FSD that the kitchen initially had not sent any cereal, then sent Rice Krispies and then sent regular oatmeal, which was what he was carrying. The surveyor then asked the FSD why the resident had not received the super cereal from the beginning. The FSD said he would be following up to find out why the meal tray ticket was not followed. The FSD said, "we have a protocol for following tickets."

On 3/6/2020 at 9:10 AM, the surveyor observed the resident at the breakfast meal. The meal tray ticket included "8 oz of whole milk", the resident received only 4 oz of milk which was consumed. The CNA noted that the tray ticket had 8 oz of milk and said, "I'll get one; we have more." The CNA brought back 8 oz of fat-free skim milk and said, "there's no more regular milk." The resident drank all of the skim milk.

On 3/6/2020 at 12:42 PM, the surveyor observed the resident at the lunch meal. The meal ticket on the resident's tray included a "Dinner Roll" which the resident did not receive. When questioned about the dinner roll, the Registered Nurse on the unit said, "mechanical soft wouldn't get a roll." The resident played with the food for a while but eventually fed themselves everything that was on the tray. When interviewed on 3/11/2020 at 2:08 PM, the FSD said, "the rolls are hard from the 3rd party vendor, we can give them a piece of bread with butter as a substitute, the staff knows that." The resident's meal tray had not included a piece of bread.

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 _____	03/12/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 692	Continued From page 30	F 692		

On 3/10/2020 8:15 AM, the surveyor observed the resident ambulating around the unit. At 9:12 AM, the surveyor observed the LPN seat the resident at a dining table. The tray ticket included "super cereal," which the resident did not receive. The surveyor mentioned the lack of super cereal to the LPN, who asked a CNA to call the kitchen. Shortly after, a kitchen employee brought the resident a bowl of super cereal. At this meal, the resident refused to eat anything and started to get physically combative when the staff tried to encourage the resident to eat. When interviewed at that time, the LPN said the resident "gets moods like that at times." The LPN said they would try to get her to eat something a little later.

On 3/11/2020 at 12:46 PM, the surveyor observed the resident at the noon meal. The resident's tray ticket included "dinner roll, milk, super mashed potatoes, and frosted cake. The resident did not get any of those 4 items. The resident had received vanilla ice cream instead of the frosted cake. When interviewed on 3/11/2020 at 2:16 PM, the FSD said a whole tray of the cake had been dropped in the kitchen, so some people got substituted with ice cream because they didn't have enough cake.

On 3/11/20 at 1:28 PM, the surveyor interviewed the Registered Dietitian (RD) about Resident #7. When asked if he observed the resident at mealtimes, the RD said he had not recently watched the resident at mealtimes, stating the last time was "probably in January." The RD said the resident had been a little lethargic (sleepy) and had some behaviors which the RD referred to as "agitation." The RD said, "nursing was

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 _____	03/12/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 692	Continued From page 31	F 692		

coaxing (Resident #7)." When asked if the resident had eaten, the RD said, "it took a while, but yes." The RD further said, "from documentation and what I've seen in the past, it (resident's intake) can be variable, but a lot of times (Resident #7) does eat. When asked why he recommended the fortified foods, the RD said, "because (Resident #7) weight has kinda been going down, to even out the weight loss." The RD calculated the resident's weights and said the resident had not experienced a significant weight loss. The surveyor told the RD that the resident had received vanilla ice cream that day for lunch instead of the frosted cake. When asked about the difference between vanilla ice cream and frosted cake, the RD said the cake with icing would be better calorie-wise than ice cream. When asked, the RD said he did tray audits monthly to ensure tray accuracy and correct texture. The RD said the last tray audit he had done was on 3/6/2020, and he had not observed any inaccuracies.

On 3/5/2020 at 10:15 AM, the FSD provided the surveyor with a policy on "Accuracy and Quality of Tray Line Service" with "Effective or Revised Date 1/17/2019." Upon review, the surveyor observed that the policy included
-"all trays are checked by food service personnel for accuracy. Trays are also checked by the employees serving the trays before giving the tray to the individual."
-"the tray is checked to ensure that foods are served as listed on the menu."
-"Each tray will be checked for: correct name, room number and diet order" and "accuracy of following menu items."
-"Problems with tray accuracy are resolved immediately."

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 _____	03/12/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 692	Continued From page 32 NJAC 8:39-27.1(a)	F 692		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to maintain kitchen sanitation in a safe and consistent manner in order to prevent food borne illness. This deficient practice was evidenced by the following: On 3/4/2020 from 8:34 AM to 9:50 AM, the surveyor, accompanied by the Food Service Director (FSD), observed the following in the	F 812	I. 1. Observed Dietary Aide was provided with 1-1 re-in-service and disciplinary action on not wearing a beard net at all times while in the kitchen. All kitchen staff were re-in-serviced on importance of wearing a beard net at all time while in the kitchen on 3/4/20. 2. All storage areas were checked for cleanliness and were cleaned, Non-Inverted pan was Re-Cleaned, immediately. All kitchen staff were	4/12/20

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 _____	03/12/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 33 kitchen: 1. Upon entrance to the kitchen the surveyor observed a Dietary Aide (DA) in the coffee area. The DA had a lengthy goatee. The DA had no beard guard and the goatee was exposed. On interview the FSD stated, "Any employee with lengthy facial hair is required to wear a beard net." 2. In the paper product storage area on a lower shelf, a cleaned and sanitized chafing pan had a plastic serving spoon on the inside of the pan. The pan was not inverted and the plastic ladle had an unidentified yellow substance on the serving surface. The FSD stated, "that's trash." The FSD threw the ladle in the trash. 3. On a middle shelf in the dry ingredient room 4 cans of shredded sauerkraut were labeled with a received date of 1/5. All 4 cans had a best by date of "Dec 2018." On interview the FSD stated, "we just got those in January. I'm gonna keep them and call my rep. They wont be used for resident meals." On the same shelf a can of pear halves had a significant dent on the upper seam. The FSD stated, "I'm gonna put that with the other dented cans in the designated dented can area." The FSD put the can of pears in the designated dented can area. 4. In the reach-in refrigerator a third pan on an upper shelf contained diced turkey. The pan had no date. The FSD stated, "We cut that up last night for today's lunch. They forgot to date it." 5. In the walk-in refrigerator on top of a multi-tiered mobile cart, a plastic tray contained 15 individually prepared vanilla puddings. The	F 812	re-in-serviced on importance of keeping all storage areas/equipment of the kitchen clean at all times on 3/4/2020. 3. All cans/non-perishable food in the dry ingredient room were checked for expiration date to ensure that expired cans/non-perishable food, if any, discarded immediately and all can/non-perishable food are labeled properly. Vendor was contacted immediately to address the issue. All kitchen staff were re-in-serviced on importance of double checking the expiration date on all can goods/non-perishable food upon receiving, labeling all food properly, and addressing expired deliveries, if any, to Food Service Director immediately on 3/4/20. 4. All refrigerated food was checked for proper labeling. Unlabeled food, if any, was discarded. All kitchen staff were re-in-serviced on importance of labeling and dating of all open/pulled food immediately on 3/4/20. 5. All perishable food in walk-in refrigerator were checked immediately. Expired items, if any, were discarded at once. All kitchen staff were re-in-serviced on importance of proper food handling/storage including all ready to use food must be labeled and dated upon opening and expired food must be discarded on the expiration date by 8pm; staff were re-in-serviced on 3/4/20. 6. Identified two 10-pound logs of ground beef were discarded at once. All kitchen staff were in-serviced on proper labeling and dating of pulled perishable food from	

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 _____	03/12/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 34 puddings were "made" 2/22/20 and had a "Discard by" date of "2/27/20 at 8PM." The FSD stated they're out of date." The FSD threw the puddings in the trash. 6. On a lower shelf in the walk-in refrigerator, a sheet pan contained two 10 pound logs of ground beef. The logs/sheet pan had no dates to identify when the meat was pulled to defrost and had no use by dates. On interview the FSD stated they were pulled to thaw on Monday and were to be used for Wednesday for meat loaf. The FSD stated, "I need to get a system in place to identify the pull and use by dates." In addition, on a middle shelf an opened plastic bag contained shredded chicken. The bag had no dates. The FSD stated "I'm gonna discard it, that should have been dated." The FSD threw the shredded chicken in the trash. 7. A cleaned and sanitized stand up mixer in front of the walk-In refrigerator/freezer had an unidentified yellow substance on the housing and splash guard. The FSD instructed the cook to reclean and sanitize the stand up mixer. 8. In the walk-in freezer 2 bags of frozen collard greens were removed from their original container. The 2 bags of collard greens had no dates. On interview the FSD stated, "They were received Friday. They should be dated when removed from their original container." There were no signs of spoilage. In addition, an opened box in the rear of the refrigerator contained frozen cut corn. The box was opened and the corn was exposed. The FSD stated "that should be closed." The FSD threw the box of corn in the trash.	F 812	freezer to refrigerator. All kitchen staff were in-serviced on first-in-first-out system while handling/transferring perishable food from freezer to refrigerator; in-service was completed on 3/4/2020. 7. Stand up mixer in front of the walk-in refrigerator/freezer area was cleaned immediately. All kitchen staff were re-in-serviced on proper cleaning kitchen techniques of kitchen areas/equipment on 3/4/2020. 8. 2 bags of frozen collard greens in the walk-in freezer were discarded immediately. All remaining items in the walk-in freezer were checked; unlabeled items, if any, were discarded immediately. All kitchen staff were re-in-serviced on proper food handling including importance of labeling/dating all removed foods from their original container on 3/4/20. 9. All Dish Machine logs for the last 6 months were audited; discrepancies, if any, were addressed with FSD. All kitchen staff were re-in-serviced on importance of checking/recording of temperature/"san read" of the dish machine into the daily log 3 X daily. 10. Meat slicer on a counter in the prep area was cleaned, sanitized and covered with plastic bag immediately. All kitchen staff were re-in-serviced on proper cleaning of the kitchen equipment on 3/4/20. 11. All plates/dishes were checked; chipped plates/dishes were discarded, uncleaned plates were re-washed, all plates were placed in an inverted position	

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 _____	03/12/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 35 9. The FSD and surveyor observed the "Dish Machine Log" dated "2 Month/Year 2020." The log was not completed for breakfast and dinner on 2/26/20. The log was not completed for breakfast, lunch and dinner for the following dates: 2/27/20, 2/28/20, and 2/29/20. On interview the FSD stated, "You see what I see. I'm not trying to be funny but it didn't get done. It's a low temperature machine, does it matter?" The surveyor then asked the FSD to provide the March 2020 copy of the Dish Machine Log. The FSD left the office to retrieve the 3/20 Dish Machine Log. After approximately 1 minute the surveyor left the FSD office and returned to the kitchen. Upon entry to the kitchen, the surveyor observed the FSD and DA writing on the 3/20 "Dish Machine Log." The surveyor requested to see the copy of the log. Observation of the log revealed the following: there were no "SAN READ" (sanitizer reading) for the dates 3/1-3/4/2020. There were no "WASH TEMP" (wash temperature) recorded at the lunch meal for the 3/1-3/4/20. In addition, there were no signatures under the "SIGN" column for the Lunch column dated 3/1-3/4/20. A review of the Dinner column revealed that a "WASH" temperature was not recorded on 3/4. The "Rinse TEMP" was not recorded for the period 3/1-3/4/20. The "SAN READ" was not recorded for the period 3/1-3/5/20. No "SIGN" was recorded for the period 3/1-3/4/20. The FSD stated on interview, "It is our policy to check and record temperatures and sanitizer levels before we start washing dishes. We are not doing it thoroughly." 10. On a counter in the prep area, a cleaned and sanitized meat slicer contained unidentifiable food debris on the back side of the slicing board.	F 812	immediately. All kitchen staff were in-serviced on proper cleaning and handling of the kitchen dishes; in-service was completed on 3/5/20. 12. All unit/floor refrigerators were checked; sign regarding 5-day for outside food as per Policy and Procedures (P/P's) of the facility were placed on all outside refrigerators. All Leftover Asian Food found in the unit pantry was discarded. All nursing/kitchen staff were in-serviced on P/P's regarding leftover food storage and usage on 3/9/20; leftover food is used within 5 days or discarded. 12. The designated facility garbage area was scheduled to be cleaned on 4/9/20 contingent to acceptable weather for such. Kitchen/maintenance staff were in-serviced on proper disposal and timely reporting of pick up time of outside grease with facility vendor. 13. "Gold Medal" trash dumpster was picked up on 3/27/20 with further restriction of placing such in garbage pick up area. Kitchen/maintenance staff were in-serviced on timely reporting on any restricted garbage containers on the facility premises. 14 The area surrounding the trash compactor and kitchen grease storage was cleaned. Kitchen/housekeeping staff were in-serviced on keeping the area clean and disposing trash properly. 15. A plastic bag contained individual frozen cookie dough was discarded immediately.	

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 _____	03/12/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 36 The meat slicer was not in use at the time, had no cover, and was exposed. The surveyor observed the FSD instruct staff to reclean and sanitize the meat slicer. On 3/5/20 from 11:32 AM to 12:03 PM, the surveyor, accompanied by the DA, observed the following on the [redacted] Dining Room: 1. On a prep/serving area table between the cold and hot steam tables the surveyor observed a cleaned and sanitized plate that was to be used to serve residents at the lunch meal that day. The surveyor observed one plate to have a significant chip on the edge of the plate. On interview the DA stated, "That shouldn't be used because it has a chip in it." Further observation noted two additional cleaned and sanitized plates that had unidentified food debris on the eating surface of the plate. On interview the DA stated, "Oh yeah, I see that. I grabbed these out of the rack of clean dishes in the kitchen." The DA removed the chipped and dirty plates from the stack of dishes. Further observation of the cleaned and sanitized plates noted that they were not in an inverted position and the eating surface of the plates was exposed. On interview the DA stated, "I was not aware of that. I will keep them inverted prior to use from now on." On 3/9/20 from 11:19 AM to 11:27 AM, the surveyor, accompanied by the Licensed Practical Nurse (LPN), observed the following on the Vent Unit: 1. A brown paper bag dated 2/28/20 was observed in the dorm style refrigerator. The bag was labeled with a resident's name and appeared to contain Asian takeout food. The surveyor	F 812	Kitchen staff were re-in-serviced on proper food handling, including dating and storing appropriately removed from the original container package; in-service was completed on 3/11/20. 16. All Dietary assistants's were re-in-serviced on infection control P/P's, including proper hand washing with returned demonstration on 3/12/2020. 17. The beverage pitcher with label in black marker "Bleach Don't" was removed and discarded immediately. All kitchen staff were in-serviced on proper storage/labeling/usage of kitchen chemicals on 3/12/20. II. All residents have the potential to be affected by the same deficient practices. III. Wall container for the beard nets will be installed outside of the kitchen by the regular hair net container for proper usage. All kitchen staff will be in-serviced on proper infection control/beard/hair net usage while in the kitchen. Detailed cleaning schedule will be implemented for each kitchen assignment with signing off upon completion of the assignment in the cleaning assignment sheet daily. All kitchen staff will be in-serviced routinely by Food Service director/Dietician on implemented cleaning assignment schedule/cleaning sheet to ensure all kitchen areas/equipment are cleaned/sanitized/stored based on facility P/P's.	

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 _____	03/12/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 37 interviewed the LPN on how long food from the outside of the facility can be stored in the refrigerator. The LPN responded, "I think 48 hours. That needs to be thrown away it's been in here too long." The LPN threw the food in the trash. On 3/11/20 from 11:12 AM to 11:47 AM, the surveyor, accompanied by the Cook Supervisor (CS), observed the following in the kitchen: 1. There were two 55 gallon drums in the designated facility garbage area; one drum was covered with a metal lid and the other drum, that contained what appeared to be used cooking oil, was opened and exposed. The drum was labeled "Kitchen Grease Only." The ground surrounding the drum and the trash compactor area was black and appeared to be oily/greasy. The CS stated, "That oil drum shouldn't be stored like that, it will attract rodents. The grease should be stored away from here. This area needs to be cleaned up." 2. The surveyor observed a "Gold Medal" trash dumpster in the parking lot. The dumpster contained bags of trash that filled the dumpster to the top. The dumpster had no cover to contain the trash. On interview the CS stated, "This isn't our kitchen trash, I don't know where this came from, all this doesn't belong here." On 3/10/2020 at 12:17 PM, the surveyor interviewed the FSD. On interview the FSD stated, "The dumpster out back doesn't belong to us. It belongs to the detox center next door. I don't know why it is on our property." The FSD further stated, "I'm gonna call the company and get them to come and take that grease. It should have been covered last night because we changed the fryer oil last	F 812	Food service director/Dietician will conduct weekly inspections of all received/stored can/non-perishable food in dry storage room to ensure proper labeling/dating. All kitchen staff will be in-serviced on facility P/P's on proper food storage/dating. Food service director/Dietician will conduct weekly audits on proper labeling/dating of all refrigerated food. All Kitchen staff will be in-serviced routinely on proper handling/storage/labeling/dating of all refrigerated perishable food. Food service director/Dietitian/Cook Supervisor will monitor daily temperature log of the dish machine to ensure that temperature/"sun usage" are recorded accurately, 3 X daily. All kitchen staff will be in-serviced routinely on proper dish machine temperature recording. Food service director/Dietitian/Cook Supervisor will perform weekly audits of kitchen dishes to identify/discard chipped dishes if any. All kitchen staff will be in-serviced routinely on proper cleaning and handling of the kitchen dishes. Food service director/Dietitian will conduct weekly audits of the floor refrigerators to ensure proper dating/storage of outside leftover food. All staff will be in-serviced routinely on proper storage of the outside leftover food. Food service director/Environmental service director will conduct weekly audit	

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 _____	03/12/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 38 night." 3. The area surrounding the trash compactor and kitchen grease storage was littered with cardboard, plastic bags, and rubber gloves. The CS stated, "This area shouldn't be like this. We need to get it cleaned up." 4. In the walk-in freezer on an upper shelf, a plastic bag contained individual frozen cookie dough that was dated 3/15. The bag was opened and the cookie dough was exposed. The CS stated, "Those shouldn't be stored like that." The CS removed the cookies from the freezer and threw the cookies in the trash. 5. The surveyor observed a DA wash her hands at the designated hand washing sink. The DA wet her hands and applied soap. The DA performed vigorous hand washing for 13 seconds then rinsed her hands under running water. The DA then obtained a hand towel and dried her hands, then turned off the water with the hand towel. The DA then threw the hand towel in the trash. 6. On the top of a wire storage rack, a beverage pitcher was filled approximately 1/3 of the way with a yellowish/green liquid. The pitcher was covered on top with plastic wrap. The beverage pitcher had the following label written in what appeared to be black marker "Bleach Don't." The rest of the writing was not legible. The CS stated, "I'm throwing that whole thing away. Chemicals shouldn't be stored in a beverage pitcher." (The chemical storage room was a locked room and could only be opened by a key). The surveyor reviewed the MIMA Healthcare facility policy titled "Guidelines for Foods Brought	F 812	of the outside garbage/grease area to ensure proper disposal and timely pick up of trash/grease by facility vendor. Kitchen staff/housekeeping staff will be in-serviced routinely on proper disposal of trash/grease to ensure cleanliness of the garbage area. Infection Preventionist /Food service director will conduct a random audit of hand washing of kitchen staff to ensure proper hand washing technique. All kitchen staff will be in-serviced routinely on proper hand washing techniques by Infection preventionist. Food service director/Dietitian will conduct weekly audits on proper kitchen chemical storage/labeling/usage. All kitchen staff will be in-serviced routinely on proper kitchen chemical storage/labeling/usage. IV. Food service director/Infection preventionist /Environmental service director will conduct routine audits of following areas: - proper usage of hair protection, including beard/hair nets in the kitchen. - completion of cleaning assignments of kitchen areas/equipment with recording into daily assignment cleaning sheet. - all refrigerated food is properly dated/labeled/stored. - all can/non-perishable food is stored/dated/labeled/used according to the facility P/P's. - all outside leftover food is stored/dated/labeled according to the facility P/P's.	

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 _____	03/12/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 39 from the outside by Family and Visitors", effective or revised date 1/17/2019. The policy noted the following at 6 and 7: 6. "Perishable foods must be stored in re-sealable containers with tight fitting lids in the refrigerator. Containers will be labeled with resident's name, the items and the "use by" date. The use by date should be 5 days after food is brought in." 7. "Nursing staff is responsible for discarding perishable foods on or before the "use by" date.' The surveyor reviewed the MIMA Healthcare facility policy titled "Food Storage", effective or revised date 1/17/2019. Under the Procedures section the policy noted the following: 5. "Chemicals must be clearly labeled, kept in original containers when possible, and kept in a locked area and stored away form food." 8. (d.) "Date marking to indicate the date or day by which a ready-to-eat, potentially hazardous food should be consumed, sold or discarded will be visible on all high risk food (see chart on next page). 8. (e.) "Foods will be stored and handled to maintain the integrity of the packaging until ready for use. (Food stored in bins may be removed form its original packaging). 13. "Leftover food is stored in covered containers or wrapped carefully and securely. Each item is clearly labeled and dated before being refrigerated. Leftover food is used within 5 days or discarded. (Also see policy on Use of	F 812	- all kitchen chemicals are stored/labeled/used based on the facility P/P's. - garbage/grease outside area is kept clean/covered and removed according to established schedule. - proper hand washing technique by kitchen staff. All mentioned audits will be completed weekly X 4 weeks, then bi-weekly X 4 weeks, then monthly. Results of the audits will be presented to the monthly QAPI meetings for review and revision as deemed appropriate.	

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 _____	03/12/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 40	F 812		

Leftovers in this section.)

14. Refrigerated Food Storage:

(f.) "All foods should be covered, labeled and dated. All foods will be checked to assure that foods (including leftovers) will be consumed by their safe use by dates, or frozen (where applicable) or discarded."

15. Frozen Foods:

f. "Frozen meat, poultry and fish should be defrosted in a refrigerator for 24 to 48 hours, and should be used immediately after thawing."

g. "All foods should be covered, labeled and dated. All foods will be checked to assure that foods will be consumed by their safe use by dates or discarded. All foods should be checked so as to show no negative outcome (e.g., freezer burn, foods dried out, foods with a change in color).

The surveyor reviewed the MIMA Healthcare facility policy titled "Dish Machine Temperature Log", effective or revised date 1/17/2019. The policy noted the following under the Policy section:

"Dishwashing staff will monitor and record dish machine temperatures to assure proper sanitizing of dishes."

In addition the policy noted the following under the Procedure section:

1. The food service manager will provide the dishwashing staff with a log to be posted near the

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 _____	03/12/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 41	F 812		

dish machine (See sample form next page).

2. The food service manager will train dishwashing staff to monitor dish machine temperatures throughout the dishwashing process."

3. Staff will be trained to record dish machine temperatures for the wash and rinse cycles at each meal.

4. The food service manager will spot check this log to assure temperatures are appropriate and staff is actually monitoring dish machine temperatures.

The surveyor reviewed the MIMA Healthcare facility policy titled "Use by Date/Opened on Date", number 82, effective or revised date 1/17/2019.
Under Policy the following was noted:

"All food items that are thawed prepared or removed from their original container will have an Expiration Date or a Use by Date. Foods in original container will have an open date." Under the Guidelines section the policy revealed the following:

1. "The food Service Director will ensure foods removed from original container will have use by date."

2. "All kitchen Staff and Nursing will be In Serviced on Labeling Procedures."

6. "Foods opened in their original containers require an open date."

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 _____	03/12/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 42	F 812		

The surveyor reviewed the MIMA Healthcare facility policy titled "General Food Preparation and Handling", number 50, effective or revised date 1/17/2019. The policy noted the following under the Procedure section:

2. Food Storage:

c. "Food in broken packages or swollen cans, cans with a compromised seal, or food with an abnormal appearance or odor will not be stored."

The policy also revealed the following at 5. Equipment:

a. "All food service equipment should be cleaned, sanitized, dried, and reassembled after each use."

b. "Plastic-ware or dishware that has lost its glaze or is chipped or cracked must be disposed of."

The surveyor reviewed the MIMA Healthcare facility policy titled "General HAACP Guidelines for Food Safety", number 47, effective and revised date 1/17/2019. The policy noted the following at Procedure 10. Dishwashing:

"Be sure the wash and rinse temperatures are appropriate for your dish."

"Document temperatures regularly on a temperature log."

The surveyor reviewed the Silver Healthcare Center facility policy titled "Policy and Procedure: Hand Hygiene", reviewed 2-17-20. The policy noted the following per the Skill: Hand Hygiene

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 _____	03/12/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 43 sheet: "Rub hands palm to palm, right palm over left dorsum with interlaced fingers and vice versa, palm to palm with fingers interlaced, back of fingers to opposing palms with fingers interlocked, rotational rubbing of left thumb clasped in right palm and vice versa for 20 sec." NJAC 8:39-17.2(g)	F 812		
F 814 SS=D	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to provide a sanitary environment for residents, staff and the public by failing to keep the garbage container area free of garbage and debris; and, failed to have a cover over the opening of 1 of 1 dumpster and 1 of 2 kitchen grease containers. This deficient practice was evidenced by the following: On 3/11/2020 from 11:12 AM to 11:47 AM, the surveyor, accompanied by the Cook Supervisor (CS), observed the following in the kitchen: 1. There were two 55 gallon drums in the designated facility garbage area; one drum was covered with a metal lid, and the other drum that contained what appeared to be used cooking oil was opened and exposed. The drum was labeled "Kitchen Grease Only." The ground surrounding the drum and the trash compactor area was black and appeared to be oily/greasy. The CS	F 814	I. 1. All garbage and rubbish containing food waste were placed into the garbage containers. 2. All containers were covered with tight-fitting lids. All uncovered containers were removed from the garbage area. Oil/Grease was cleaned up immediatly and removed. 4. Garbage pick of uncovered container was done 3/27/2020. All kitchen staff was in-serviced on proper garbage handling/disposal/coverage. II. All residents have the potential to be affected by the same deficient practice. III. Food service director/Environmental service director will conduct weekly audits of the garbage area to ensure cleanliness/proper garbage handling. All kitchen/housekeeping staff will be	4/12/20

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 _____	03/12/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 814	Continued From page 44 stated, "That oil drum shouldn't be stored like that, it will attract rodents. The grease should be stored away from here. This area needs to be cleaned up." The surveyor reviewed the MIMA Healthcare policy titled "Garbage & Rubbish Disposal," number 78, effective or revised date 1/17/2019. The policy noted the following under the Guidelines section: 1. "All garbage and rubbish containing food waste shall be kept in containers." 2. "All containers shall be provided with tight-fitting lids or covers, and such containers must be kept covered when stored or not in continuous use." 5. "Garbage and rubbish containing food waste shall be stored as to be inaccessible to vermin." 8. "Outside dumpsters provided by a garbage pick up services must be kept closed and free of litter around the dumpster area." NJAC 8:39-19.3(c)	F 814	in-serviced routinely on proper garbage handling/storage. IV. Food service director/Enviromental service director will conduct routine audits of the garbage area to ensure proper handling of garbage and cleanliness of the area weekly X 4 weeks, then bi-weekly X 4 weeks, then monthly. Results of the audits will be presented to the monthly QAPI meetings for review and revision as deemed appropriate.	
F 880 SS=E	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	F 880		4/12/20

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 _____	03/12/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 45	F 880		

program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§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

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 _____	03/12/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 46 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. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to maintain contact isolation precautions for 2 of 2 residents (Resident #24 and #172) reviewed for isolation. This deficient practice was evidenced by the following: 1. The surveyor reviewed the medical record of Resident #172 and observed an 11/26/2019 Physician's Order for the resident to be on contact isolation for [redacted]) On 3/9/2020 at 1:55 PM the surveyor observed a sign on Resident #171's room door that instructed people to "STOP see nurse before entering and to utilize gloves, hand hygiene, and gown" as well as a 3 drawer clear plastic container outside the resident's room that held the supplies required to don proper Personal	F 880	1. Resident #172, and # 24 were Re-evaluated for continued need of Isolation, Both care plans were reviewed for Accuracy. Both residents will continue isolation. 2. All residents on Isolation have the potential to be affected by this practice. All residents in house on Isolation were immediately audited to ensure staff on those units are wearing, and disposing of PPE properly, All Staff were RE-Educated on 3-11-20 and ongoing on Infection control and transmission based precaution policies and procedures, Donning and doffing PPE, and Hand washing via Competencies with return demonstration. This will be ongoing. 3. The Assistant Director of	

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 _____	03/12/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 47 Protective Equipment (PPE). At that time, the surveyor observed a Licensed Practical Nurse (LPN) enter the isolation room without donning PPE. When interviewed at that time, the LPN acknowledged that Resident #171 was on contact isolation for [redacted]. When interviewed on 3/11/2020 at 4:59 PM, the Director of Nursing stated that if a resident is on contact precautions, her expectation is that the isolation instructions on the signs outside of resident rooms should be followed. 2. During an initial tour of the facility on 3/4/2020 at 10:11 AM, the surveyor asked the Registered Nurse/Unit Manager (RN/UM) if there were any residents on the floor who were on isolation precautions. The RN/UM stated, "Resident #24 is on contact isolation for [redacted] The surveyor then asked the RN/UM what type of PPE should be donned before entering the resident's room. The RN/UM stated, "Anybody who enters the room must have gown and gloves." The surveyor also observed a 3-compartment plastic storage unit outside of the resident's room and signage, noting "STOP" before entering the room and signage detailing "contact precautions." On 3/4/2020 at 10:17 AM, the surveyor observed a female staff member enter the room of Resident #24 without gown and gloves. The staff member then exited the room carrying a meal tray. The surveyor observed the staff member place the meal tray on a multi-tiered wheeled cart in the hallway. Upon placing the meal tray on the cart, the RN/UM approached and asked the staff if she had just entered Resident #24's	F 880	Nursing/Director of Nursing/Infection Preventionist will ensure that all existing staff in each respective department continues to have an understanding of who is on isolation and procedures to go in and out of a room wearing proper PPE staff will continue to perform a competency for PPE, hand washing, and 1:1 education will be given with written feedback to those who break infection control protocols up to and including progressive discipline for further breach thereafter. 4. The Infection Preventionist /Assistant director of nursing Will Perform Environmental rounds on each unit on a weekly basis with unit manager. During rounds the Infection Preventionist will observe anyone who is on isolation for that unit, ensure PPE Adherence , and Perform Random Hand Hygiene Audits using the Environmental Rounds Audit tool. Immediate education and feedback will be provided to those staff who were found not to adhere if any. The Audit will be done weekly x 6 weeks then Bi-Weekly X 4 weeks, then monthly; however, depending on the results this may be performed more frequently as requested by the Director of Nursing. Results of the audits will be presented to the monthly QAPI meeting for review and revision as deemed appropriate.	

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 _____	03/12/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 48	F 880		

room without gown and gloves. The staff responded, "yes." The RN/UM stated, "That is an isolation room, and you need to have gown and gloves on. You need to come with me immediately to wash your hands so that you do not spread infection." Upon completion of washing her hands, the female staff member returned to the hallway to collect additional meal trays from the breakfast meal.

When interviewed at that time, the staff member identified herself as a Dietary Aide (DA) and stated, "I collect the trays on all the floors, but no one told me I have to wear gloves, gown, and mask when I enter the room. The nurses never told me that." The surveyor asked the DA if she had observed the signage on Resident #24's doorway before entering the room. The DA stated, "The sign tells me to stop and go to the nursing station before entering the room. I'm sorry. The next time I will wear a gown and gloves."

When interviewed on 3/4/2020 at 10:27 AM, the Licensed Nursing Home Administrator (LNHA), who had arrived on the hallway upon completion of the surveyor's interview with the DA, stated, "She will be inserviced again. She has already been inserviced previously. She should have had a gown and gloves prior to entering the room. I am going to have my Infection Preventionist (IP) person inservice her right now." The surveyor then observed the IP inservice the DA on how to properly don gown and gloves prior to entering the isolation room.

The surveyor reviewed the resident's medical record and observed a 2/17/2020 Physician's Order (PO) for "contact precautions-[redacted]"

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 _____	03/12/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 49 [redacted] In addition, the surveyor observed a 2/27/2020 PO for "continue contact precautions for [redacted] NJAC 8:39-27.1(a)	F 880		