STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315280	A. BUILDING **01** B. WING _____	**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
E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
K 000	INITIAL COMMENTS LIFE SAFETY CODE 101:2012 The facility is not in substantial compliance with the minimum Life Safety Code requirements as surveyed under CMS-2786R.	K 000		
K 223 SS=D	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 3/10/20, in the presence of facility management, it was determined that the facility failed to provide and maintain self-closing doors to hazardous areas and stairway enclosures.	K 223	I. 1. Thinner magnetic lock was ordered and installed to exit stairway access door from the [redacted] dining room to the inner stairway to ensure proper closure. 2. Self-closing device of the [redacted]	4/12/20

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

Electronically Signed | 04/03/2020

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K 223	Continued From page 1 This deficient practice was evidenced by the following: 1. At 10 AM, the surveyor and the facility's Director of Maintenance (DM) observed that the exit stairway access door from the [redacted] dining room to the inner stairway had a 1-inch gap around the frame in the closed position. Further observations revealed that the magnetic locking device was installed in a manner that prevented the door from closing all the way to the frame. When interviewed at that time, the DM confirmed the magnet was the issue and stated he would get it repaired with a thinner magnet. 2. At 10:25 AM, the surveyor and the DM observed that the door to the [redacted] supply room by resident room [redacted] was provided with a self-closing device, but the door failed to close to the frame when tested. 3. At the same time, the surveyor and the DM observed the other supply room across the corridor. The door to this supply room was not provided with a self-closing device. The supply room was greater than 50 square feet and contained combustible supplies. 4. At 10:48 AM, the surveyor and the DM observed that the [redacted] storage room across from the fish tank also had no self-closing device. This room measured greater than 50 square feet and contained combustible supplies. In an interview at 3:30 PM, the DM stated that the doors would be fixed to be compliant. NJAC 8:39-31.1(c), 31.2(e)	K 223	supply room door by room [redacted] was adjusted to insure proper closure. 3. Self-closing device was installed on the door of the supply room across the corridor to ensure proper closure. 4. Self-closing device was installed on the door of the [redacted] storage room across from the fish tank. All maintenance staff were in-serviced on importance of checking/addressing any issues related to the proper closure of all doors in the facility. II. All self-closing doors were checked to ensure that they closed entirely and that the closures were installed and operating properly. III. All self-closing doors will be checked weekly by the maintenance staff Environmental Services Director (ESD). Findings, if any, will be recorded into the Maintenance check list. Staff will be re-educated on reporting any doors that are not operating properly into the maintenance log book. IV. ESD/Administrator will conduct weekly environmental rounds/random audits of the maintenance checklist to ensure that all self closing doors close properly and, if not, recorded into the maintenance log book in order to address issue to ensure proper door closure. Weekly rounds/random audits will be done by ESD/Administrator 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	

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K 223	Continued From page 2	K 223	appropriate.	
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices,	K 363		4/12/20

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K 363	Continued From page 3 etc. This REQUIREMENT is not met as evidenced by: Based on observation and interview on 3/9/20 and 3/10/20, in the presence of facility management, it was determined that the facility failed to maintain doors to rooms in exit corridors to close and provide protection from the passage of smoke to the exit corridors. This deficient practice was evidenced by the following: Throughout a tour of the facility, beginning on 3/9/20 through 3/10/20, the surveyor and the facility's Director of Maintenance (DM) observed doors in exit corridors that would not close and would not protect from the passage of smoke as follows: 1. The door to resident room [redacted] closed with a 1/2 inch gap, and the door exceeded the door-stop. 2. The door to resident room [redacted] did not latch into the frame. 3. The door to resident room [redacted] closed with a gap greater than 1/2 inch. 4. The door to the MDS office exceeded the door-stop. 5. The door to resident room [redacted] had a gap on the side in the middle greater than 1/2 inch. 6. The door to resident room [redacted] had a gap along the top that exceeded the door-stop. 7. The door to resident room [redacted] had a gap	K 363	I. 1. The door to resident room [redacted] was adjusted to ensure proper closure. 2. The door to resident room [redacted] was adjusted to ensure proper closure. 3. The door to resident room [redacted] was adjusted to ensure proper closure. 4. The door to the MDS office was adjusted to ensure proper closure. 5. The door to resident room [redacted] was adjusted to ensure proper closure. 6. The door to resident room [redacted] was adjusted to ensure proper closure. 7. The door to resident room [redacted] was adjusted to ensure proper closure. 8. The doors to resident rooms [redacted] and [redacted] were adjusted to ensure proper closure. 9. The door to the [redacted] Unit staff lounge was adjusted to ensure proper closure. 10. The door to resident room [redacted] was adjusted to ensure proper closure. 11. The door to resident room [redacted] was adjusted to ensure proper closure. 12. The door to resident room [redacted] was adjusted to ensure proper closure. 13. The door to the Director of Nursing Office was adjusted to ensure proper closure. 14. The door to resident room [redacted] was adjusted to ensure proper closure. All maintenance staff were in-serviced on checking all doors through their daily rounds and recording findings, if any, to the maintenance daily round sheet for repair/readjustment to ensure proper closure.	

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K 363	Continued From page 4 along the top that exceeded the door-stop. 8. The doors to resident rooms [redacted], and [redacted] had a gap greater than 1/2 inch. 9. The door to the [redacted] Unit staff lounge had a gap greater than 1/2 inch. 10. The door to resident room [redacted] had a gap along the top that exceeded the door-stop. 11. The door to resident room [redacted] had a gap at the bottom side that exceeded the door-stop. 12. The door to resident room [redacted] had a gap along the top and the side that exceeded the door-stop. 13. The door to the Director of Nursing Office had a gap along the top that exceeded the door-stop. 14. The door to resident room [redacted] would not stay closed to the frame and had a gap at the top that exceeded the door-stop. In an interview on 3/10/20 at 3:30 PM, the DM stated he needed to check all the doors. NJAC 8:39-31.1(c), 31.2(e)	K 363	All staff were in-serviced on reporting any problems with doors at their units through recording issues, if any, to the maintenance log book. II. All doors were checked to ensure that they closed properly and all doors, if any, that needed readjustment were fixed and closed properly. III. Environmental Services Director/Maintenance Supervisor will conduct weekly rounds to ensure all doors have proper closure. Maintenance staff will be in-serviced routinely on importance of checking all facility doors for proper closure and reporting/repairing of findings, if any, to ensure proper closure of all doors. IV. ESD/Administrator will conduct environmental rounds/audits on proper closure of all doors in the facility 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.	
K 374 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors	K 374		4/12/20

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K 374	Continued From page 5 are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 3/9/20 and 3/10/20, in the presence of facility management, it was determined that the facility failed to maintain smoke barrier doors to close to provide at least 20 minutes of fire protection on 3 of 4 resident sleeping units. This deficient practice was evidenced by the following: 1. On 3/9/20 at 1:40 PM, the surveyor and the facility's Director of Maintenance (DM) observed that the smoke barrier doors by the Nurse Practitioner's Office on the [redacted] Unit did not close when released from the magnetic hold-open devices. One of the double doors bounced back from the frame and would not latch, creating a gap along the meeting edges. 2. On 3/10/20 at 10:10 AM, the surveyor and the DM observed that the smoke barrier doors on [redacted] to [redacted] did not close to the frame. One of the double doors had a closer that was not strong enough to close the door leaving the door open several inches. 3. At 10:45 AM, the surveyor and the DM observed that the smoke barrier doors on Court 1 to [redacted] did not close to the frame. When released from the hold-open device, one of the	K 374	I. 1. Smoke barrier door by the Nurse Practitioner's Office of the [redacted] Unit was readjusted for proper closure on 3/9/20. 2. A closer of the smoke barrier door on [redacted] to [redacted] was sized up and replaced for proper closure on 3/9/20. 3. The smoke barrier door on [redacted] to [redacted] was adjusted for proper closure on 3/9/20. All doors of the building were re-assessed for proper closure. Doors with problem, if any, were fixed/re-adjusted. Maintenance staff was in-serviced on importance of checking of all doors for proper closure through daily rounds and reporting/fixing if any door has improper closure immediately. II. All smoke barrier doors were checked to ensure that they closed entirely and that the closures were installed and operating properly. III. All smoke barrier doors will be checked weekly by the maintenance staff Environmental Services Director (ESD). Findings, if any, will be recorded into the Maintenance check list. Staff will be re-educated on reporting any	

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K 374	Continued From page 6 doors hit the latching mechanism and would not close automatically. In an interview at 3:30 PM, the DM stated he would have to check all the doors in the building for compliance. NJAC 8:39-31.1(c), 31.2(e)	K 374	doors that are not operating properly into the maintenance log book. IV. ESD/Administrator will conduct environmental rounds/random audits of the maintenance checklist to ensure that all smoke barrier doors close properly and, if not, recorded into the maintenance log book in order to address issue to ensure proper door closure. Weekly rounds/random audits will be done by ESD/Administrator 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.	
K 741 SS=E	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted.	K 741		4/12/20

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K 741	Continued From page 7 (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 3/9/20 and 3/10/20, in the presence of facility management, it was determined that the facility failed to maintain smoking areas in safe condition; and, failed to dispose of smoking refuse safely at 3 locations. This deficient practice was evidenced by the following: 1. On 3/9/20 at 9:30 AM, the surveyor observed that there were approximately 25 cigarette butts on the cement patio to the left of the entrance. The area was provided with a smoking extinguishing station, but cigarette butts littered the patio. 2. At 2:05 PM, the surveyor and the facility's Director of Maintenance (DM) observed the staff smoking area courtyard outside the [redacted] Unit. Observations included a smoking station base that was overflowing with cigarette butts and combustible trash, cigarette butts along the grounds, and a plastic soda bottle mixed with cigarette butts inside a smoking station. When interviewed at that time, the DM stated his staff is supposed to clean the area and empty the smoking stations daily. 3. On 3/10/20 at 10:50 AM, the surveyor and the DM observed that there were more than 100	K 741	I. 1. All cigarette butts were removed from the cement patio to the left of the entrance immediately. All staff were re-in-serviced on facility smoking policy and procedures (P/P's), including smoking only in designated areas and disposing of the cigarette butts and trash appropriately. 2. Smoking area courtyard outside the [redacted] Unit was cleaned immediately. All housekeeping staff were re-in-serviced on smoking P/P's, including keeping smocking areas clean through increasing cleaning smoking area routine from 1- to 2 X daily. 3. All cigarette butts mixed with dry vegetation along the curbing at the loading dock near the liquid and compressed Oxygen storage room were cleaned immediately. All staff were re-in-serviced on smoking P/P's including danger/restriction of smoking near the oxygen room. II. All smoking areas were checked and all cigarette butts, if any, were removed and areas were cleaned if needed on 3/9/20. III. Environmental Services Director/Maintenance Supervisor will conduct weekly environmental rounds in	

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K 741	Continued From page 8 cigarette butts mixed with dry vegetation along the curbing at the loading dock near the liquid and compressed Oxygen storage room. In an interview at that time, the DM stated the area was not designated for smoking. NJAC 8:39-31.2(e)	K 741	order to ensure that all smoking areas are cleaned 2 X day and remain cigarette butts free. All staff will be in-serviced routinely on smoking P/P's, importance of smoking in designated areas and keeping these areas clean by disposing all trash, including cigarette butts properly. Environmental Service Director/Maintenance Supervisor will conduct weekly environmental rounds to ensure all staff follow smoking P/P's, smoke in strictly designated areas and dispose cigarette butts/trash properly. IV. Environmental Services Director/Administrator will conduct environmental rounds and random audits on staff following smoking P/P's, including smoking at designated areas, disposing cigarette butts/trash properly and all smoking designated areas remaining clean. These rounds 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.	