

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

PRINTED: 03/18/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315280	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/08/2019
NAME OF PROVIDER OR SUPPLIER SILVER HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 COMPLAINT # NJ 116914 CENSUS: 196 SAMPLE SIZE: 3	F 000			
F 584 SS=E	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; §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);	F 584		11/9/19	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

12/16/2019

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315280	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/08/2019
NAME OF PROVIDER OR SUPPLIER SILVER HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>Continued From page 1</p> <p>§483.10(i)(5) Adequate and comfortable lighting levels in all areas;</p> <p>§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</p> <p>§483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: COMPLAINT # NJ 116914</p> <p>Based on observations, interviews, review of Medical Records (MR), as well as review of pertinent facility documents on 11/8/2019, it was determined that the facility failed to maintain residents' environment and equipment in good repair and in good sanitary condition and failed to follow their Policy titled " Quality of Life-Homelike Environment." This deficient practice was identified for multiple rooms on the [REDACTED] and is evidenced by the following:</p> <p>During a Unit Tour on 11/8/2019 at 9:30 a.m., accompanied by the Unit Manager (UM) on the [REDACTED], the surveyor inspected resident rooms and noted the following:</p> <ol style="list-style-type: none"> Room [REDACTED], a semi private room, on unoccupied side, front panel missing on heater. Two holes in the wall. Call bell panel missing cover. Missing light fixtures in the room. Room [REDACTED] front panel missing on heater. Room [REDACTED] the heater/air conditioner vent cover was cracked. Room [REDACTED] the heater/air conditioner vent cover was cracked. 	F 584	<ol style="list-style-type: none"> Room [REDACTED] - front panel of PTAC unit was placed, two holes fixed, call bell panel placed, light fixtures installed. Room [REDACTED] - missing PTAC panel was placed. Room [REDACTED] - PTAC cover was replaced. Room [REDACTED] - PTAC cover was replaced. Room [REDACTED] faucet was replaced. Room [REDACTED] - locks were replaced, room was deep cleaned/stripped and waxed, PTAC cover was placed. Room [REDACTED] - PTAC cover was replaced. Room [REDACTED] - PTAC cover was placed. Room [REDACTED] - PTAC cover was placed, room was deep cleaned/ stripped and waxed, dirty toilet tissue was removed immediately. Room [REDACTED] - bedside nightstand was replaced, room was deep cleaned/stripped and waxed. Room [REDACTED] - PTAC cover was placed. Room [REDACTED] - PTAC unit was cleaned, bedside nightstand was replaced. Room [REDACTED] - dirty diapers/used gloves/dirty paper towels removed from the floor immediately, garbage cane was 		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315280	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/08/2019
NAME OF PROVIDER OR SUPPLIER SILVER HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>Continued From page 2</p> <p>5. Room [REDACTED] running water in the sink. The Unit Manager was unable to shut the water off.</p> <p>6. Room [REDACTED] both locks on the closet were broken off and unable to lock the closet. Large brown stain on the floor under the window. No cover on heater/air conditioner vent.</p> <p>7. Room [REDACTED] cracked vent cover on heater/air conditioner unit.</p> <p>8. Room [REDACTED], missing cover on heater/air conditioner unit.</p> <p>9. Room [REDACTED] missing panel on heater/air conditioner unit. Feces smeared on toilet seat and dried feces on the floor. Dirty toilet tissue on the floor.</p> <p>10. Room [REDACTED], the bedside nightstand, drawer front was missing. The floor was very sticky throughout the room.</p> <p>11. Room [REDACTED], missing vent cover on heater/air conditioner unit.</p> <p>12. Room [REDACTED], heater/air conditioner vent extremely dirty. Front of bedside nightstand drawer front missing and observed lying on the floor.</p> <p>13. Room [REDACTED], observed dirty diapers, used gloves and dirty paper towels on the bathroom floor. No garbage can was in the room. Door knob missing from room entrance door.</p> <p>14. Room [REDACTED] plastic covering the heater/air conditioner unit. (Staff reported the unit is broken.)</p> <p>15. Room [REDACTED] missing vent cover on heater/air conditioner unit.</p> <p>16. Five heater/air conditioner units were observed in the Activity room. One was without a vent cover in place.</p> <p>During an interview on 11/8/2019 at 9:45 a.m., the Unit Manager stated, the brown spot on the floor in room [REDACTED] "It looks like rust."</p>	F 584	<p>placed, door knob was placed.</p> <p>14. Room [REDACTED] - PTAC cover was placed, unit was working.</p> <p>15. Room [REDACTED] - PTAC cover was placed.</p> <p>16. Activity Room - PTAC vent cover was placed.</p> <p>- All housekeeping staff were rein-serviced on P/P's on Bathroom Cleaning.</p> <p>- All staff were rein-serviced on importance of identifying/reporting/recording all maintenance issues into the maintenance log that locates at the nursing unit.</p> <p>II. All residents having the potential to be affected by the same deficient practice.</p> <p>III.</p> <p>- Department Heads will continue to complete routine 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 audit check sheets.</p> <p>- All staff will be routinely in-serviced on identifying/reporting/recording all maintenance issues into the maintenance log.</p> <p>IV.</p> <p>- Administrator/Designee will continue to conduct random audits of the rooms through daily rounds.</p> <p>- Department Heads/Unit Managers will continue to complete routine rounds of assigned rooms to identify/report/record</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315280	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/08/2019
NAME OF PROVIDER OR SUPPLIER SILVER HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 During an interview on 11/8/2019 at 9:50 a.m., the Unit Manager stated, the heater/air conditioner unit had been broken for 3 to 4 weeks in room [REDACTED]. During an interview on 11/8/2019 at 12:15 p.m., the Certified Nursing Assistant (CNA) stated: If a dangerous condition or a broken item were observed the staff writes it in the maintenance book for repair. During an interview on 11/8/2019 at 1:12 p.m., the Unit Manager stated: There is a maintenance log book at the nurse's station. Any repairs that are needed the staff will write it in the book. During an interview on 11/8/2019 at 1:33 p.m., the Administrator stated: Repairs are done as soon as the staff writes it in the book. Maintenance usually takes care of the repairs the same day that it's reported. During an interview on 11/8/2019 at 1:42 p.m., the Administrator (Admin) reported, cleaning the heater/air conditioner vents is part of daily cleaning. The Admin also stated, "we only have 3 maintenance men for the whole building." During an interview on 11/8/2019 at 1:45 p.m., the Director of Maintenance (DM) stated, the door knob is missing from room [REDACTED] because the resident was locking himself in the room. The resident was later sent to crisis. In addition, the DM stated; the resident in room [REDACTED], had ripped down the lights, smoke alarm, and removed the wallpaper requiring maintenance to repair things over 20 times in the past year.	F 584	findings related to safe/clean/comfortable/homelike environment into the maintenance log book and will complete the audit check sheet for each assigned room. - 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.		

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

PRINTED: 03/18/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315280	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/08/2019
NAME OF PROVIDER OR SUPPLIER SILVER HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>Continued From page 4</p> <p>Review of the "Maintenance Service Log" from the [REDACTED] station showed the following: On 10/4/2019, staff reported the heater/air conditioner unit in room [REDACTED] needed repair. The request was signed off by maintenance, however there was no indication that the repair was completed.</p> <p>During an interview on 11/8/2019 at 1:50 p.m., the DM stated: We make rounds everyday but not every room. We try to clear the log book every day however, we get anywhere from 5 requests to 100 per day. In addition, the DM reported he was not notified the heater in room [REDACTED] was broken until today.</p> <p>Review of the Facility Policy titled "Quality of Life-Homelike Environment," dated April 2014, revealed the following under "Policy Statement;" Residents are provided with a safe, clean, comfortable and homelike environment.... Under "Policy Interpretation and Implementation" section 2; The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. Under section 3; The facility staff and management shall minimize, to the extent possible, the characteristics of the facility that reflect a depersonalized, institutional setting.</p> <p>N.J.A.C. 8:39-4.1 (a)</p>	F 584			