DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES				M APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB N	O. 0938-0391
	STATEMENT OF DEFIC ENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENT FICATION NUMBER:		. ,	LE CONSTRUCTION	Сом	E SURVEY PLETED
		315280	B. WING			С
	ROVIDER OR SUPPLIER	515200		STREET ADDRESS, CITY, STATE, ZIP CODE	05	5/12/2022
	NOVIDER OR OOI T EIER			1417 BRACE ROAD		
SILVER HI	EALTHCARE CENTER			CHERRY HILL, NJ 08034		
(X4) ID PREFIX TAG	(EACH DEFIC ENC	ATEMENT OF DEFIC ENCIES Y MUST BE PRECEDED BY FULL LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	i	F 00	0		
	COMPLAINT: #NJ1 #NJ154125	15116, #NJ153829,				
	CENSUS: 105					
	SAMPLE SIZE: 3					
	COMPLIANCE WITH 42 CFR PART 483, S	OT IN SUBSTANTIAL I THE REQUIREMENTS OF SUBPART B, FOR LONG TIES BASED ON THIS				
F 580 SS=D	Notify of Changes (In CFR(s): 483.10(g)(14	jury/Decline/Room, etc.) !)(i)-(iv)(15)	F 58	10		6/17/22
	consult with the resid consistent with his or representative(s) whe (A) An accident involv results in injury and h physician interventior (B) A significant chan mental, or psychosoc deterioration in health	ediately inform the resident; ent's physician; and notify, her authority, the resident en there is- ving the resident which as the potential for requiring n; ge in the resident's physical, cial status (that is, a n, mental, or psychosocial				
	clinical complications (C) A need to alter treat a need to discontinue treatment due to adve commence a new for (D) A decision to tran resident from the faci §483.15(c)(1)(ii).	eatment significantly (that is, an existing form of erse consequences, or to m of treatment); or sfer or discharge the				
		SUPPLIER REPRESENTATIVE'S SIGNATURI	E	TITLE		(X6) DATE
Electroni	cally Signed					06/09/2022

Electronically Signed

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.

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM APPROVED IB NO. 0938-0391
STATEMENT OF DEFIC ENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENT FICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION		DATE SURVEY COMPLETED
		315280	B. WING _			05/12/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	ODE	
SILVER H	EALTHCARE CENTER			1417 BRACE ROAD CHERRY HILL, NJ 08034		
(X4) ID PREFIX TAG	(EACH DEFIC ENC	ATEMENT OF DEFIC ENCIES Y MUST BE PRECEDED BY FULL LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF (((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	(X5) COMPLETION DATE	
F 580	all pertinent informati is available and provi physician. (iii) The facility must a resident and the reside when there is- (A) A change in room as specified in §483. (B) A change in resid State law or regulation (e)(10) of this section (iv) The facility must a update the address (in phone number of the representative(s). §483.10(g)(15) Admission to a comp that is a composite di §483.5) must disclose its physical configura locations that compris part, and must specif room changes betwe under §483.15(c)(9). This REQUIREMENT by: C#: NJ151116 Based on interviews, review of other pertin 5/10/2022 and 5/12/2 the facility failed to no responsible party for change in condition; of	the facility must ensure that on specified in §483.15(c)(2) ded upon request to the also promptly notify the dent representative, if any, or roommate assignment 10(e)(6); or ent rights under Federal or ins as specified in paragraph record and periodically mailing and email) and resident osite distinct part. A facility stinct part (as defined in e in its admission agreement tion, including the various se the composite distinct y the policies that apply to en its different locations T is not met as evidenced medical record review, and ent facility documents on 2022, it was determined that otify the Resident's	F 5	F580 1. How the corrective action accomplished for those resi have been affected by the deficient pra Based on the record review interviews and reviews of pr documents, the facility failed to notify the re	idents found to actice: / and ertinent	

Event ID: 285611 Facility ID: NJ60407

If continuation sheet Page 2 of 25

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFIC ENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULT PLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENT FICATION NUMBER: COMPLETED A. BUILDING С 315280 B. WING 05/12/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1417 BRACE ROAD SILVER HEALTHCARE CENTER CHERRY HILL, NJ 08034 SUMMARY STATEMENT OF DEFIC ENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID D (EACH DEFIC ENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENT FY NG INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 580 Continued From page 2 F 580 in Condition Monitoring" and "Wound Care and responsible party for the patient who had Prevention" for 1 of 3 residents (Resident #2). a change This deficient practice was evidenced by the of condition for one (Resident #2) of three residents reviewed for pressure ulcers. following: The A review of Resident #2's Medical Record was as resident is no longer at Silver Healthcare follows: Center. An audit of all residents with pressure According to the "Admission Record (AR)," ulcers was conducted to identify any Resident #2 was admitted to the facility on residents in need of change in condition NJ Exec. Order 26 4.b.1 with diagnoses which included, N Exec. Ord notification. Family notification complete. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice: According to the Minimum Data Set (MDS), dated 7/7/2021, Resident #2 had NJ Exec. Order 26:4.b.1 All residents have the potential to be affected by this deficient practice. . The Order 26:4.b.: MDS also showed Resident #2 needed 3. What measures will be put into place or systematic changes made to ensure that the deficient practice will not return: A review of "Admission/Re-admission Screener" DON/designee will provide retraining to all for Resident #2 dated 07/01/2021, written by the nurses regarding family notification on Licensed Practical Nurse (LPN #1), indicated change of condition. Under "Skin Integrity," 'NJ Exec. Order 26:4.b.1 Resident #2 4. How will the facility monitor its was admitted with NJ Exec. Order 26:4.b.1 corrective actions to ensure that the deficient practice A review of PNs dated 10/8/2021 at 10:13 p.m. is being corrected and will not reoccur: written by LPN #2 revealed that the Aide reported NJ Exec. Order 26:4.b.1 DON/designee will conduct weekly audits of patient pressure ulcers to ensure family Will have the notification on change of condition was wound team consulted for any recommendations. completed. This audit will continue for three (3)

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 285611

Facility ID: NJ60407

If continuation sheet Page 3 of 25

CENTER		ID HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA			FORM	D: 02/14/2023 APPROVED D: 0938-0391
	F CORRECTION	IDENT FICATION NUMBER:	. ,		COMPLETED	
		315280	B. WING			12/2022
NAME OF P	PROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
SILVER H	EALTHCARE CENTER			417 BRACE ROAD CHERRY HILL, NJ 08034		
(X4) ID PREFIX TAG	(EACH DEFIC ENC	ATEMENT OF DEFIC ENCIES Y MUST BE PRECEDED BY FULL LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 580	A review of PNs dates written by LPN #1 rev noted with NJ Exec. (with MD (physician) a A review of the "Woun Resident #2 with an e written by the Unit Ma Nurse (UM #1) with a revealed under "Wou had NJ Exec. Order A review of the WR for effective date of 11/2/ a signed date of 11/8/ "Wound 2" indicated I A review of the WR for effective date of 11/9/ a signed date of 11/1/2/ a signed date of 11/1/2/ wound 4" indicated I on 11/8/2021 and Uno Resident #2 had NJ E w treatment ordered. A review of the WR for effective date of 11/3/ w treatment ordered.	d 11/2/2021 at 9:21 p.m. vealed that Resident #2 was Order 26:4.b.1 Will follow up and wound doctor. Ind Report (WR)" for effective date of 11/2/2021 anager/Licensed Practice a signed date of 11/8/2021 Ind 1" showed Resident #2 26:4.b.1 or Resident #2 with an /2021 revealed that Under Resident #2 had Network over 2000 (2021 revealed that Under Resident #2 had Network over 2000 (2021 revealed that Under Resident #2 had Network over 2000 (2021 revealed that Under Resident #2 with an /2021 revealed that Under Resident #2 with an /2021 written by UM #1 with 2/2021 revealed under	F 580	months or until compliance is achieved Monthly report of this process will be provided to administration and a quarter report will be reported to quality assurance performance improvement committees one year.	erly	

	MENT OF HEALTH AN						FORM): 02/14/2023 MAPPROVED). 0938-0391
STATEMENT	OF DEFIC ENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		315280	B. WING			_		C 12/2022
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
SILVER H	EALTHCARE CENTER				417 BRACE ROAD CHERRY HILL, NJ 0803	4		
(X4) ID PREFIX TAG	(EACH DEFIC ENC)	ATEMENT OF DEFIC ENCIES Y MUST BE PRECEDED BY FULL .SC IDENT FY NG INFORMATION)	D PREFI TAG	x	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	effective date of 12/14 with a signed date of any ^{NU Exec. Order 26:4.b.1} for A review of a Wound Resident #2 dated 12 Consultant, Advanced A further review of the documented evidence notified Resident 2's r changes in the Reside wounds from 10/8/202 During an interview of UM #1 stated the nurs on the day of discove notification would be of (Progress) Notes (NN he notified the family During an interview of the surveyor asked th what the protocol was found. The DON state family and document During an interview of the DON stated the nurs of the DON stated the nurs family was notified.	4/2021 written by UM #1 12/14/2021 did not reveal Resident #2. Care Visit Report for /13/2021 revealed Inoted by the Wound Practice Nurse (APN). PNs showed no that the facility staff responsible party of the ent's skin condition or 21 until discharge. In 5/10/2022 at 10:25 a.m., se should notify the family ring the wound, and the documented in the Nurse's I). UM, #1 could not recall if member of the new wounds. In 5/10/2022 at 12:36 p.m., e Director of Nursing (DON) s when a new wound was ed the nurse would call the what was found in the NN. In 5/10/2022 at 3:28 p.m., urses should have inds in the NN and that the in condition includes in and when there is a f a wound. The	F	580				

Facility ID: NJ60407

If continuation sheet Page 5 of 25

	MENT OF HEALTH AN S FOR MEDICARE & I						FORM): 02/14/2023 MAPPROVED). 0938-0391
STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION A. BUILDING				(X3) DATE COMP	SURVEY LETED
		315280	B. WING			C 05/12/2022		
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE			
SILVER H	EALTHCARE CENTER				417 BRACE ROAD CHERRY HILL, NJ 08034			
(X4) ID PREFIX TAG	(EACH DEFIC ENC)	ATEMENT OF DEFIC ENCIES Y MUST BE PRECEDED BY FULL SC IDENT FY NG INFORMATION)	D PREF TAG		PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD B		(X5) COMPLETION DATE
F 580	5/16/2022, LPN #1 st was found, "I would re would follow-up with t family. During a post-survey 5/17/2022 at 2:39 p.m APN, stated for Resid consultations, the UM for her and the family consultation with Res and her last was on 1 A review of the policy Monitoring" with a rev revealed Under "Polic shall promptly notify t Attending Physician, a of changes in the resi condition and/or statu careetc.)." Under " Implementation" inclu change" of condition i improvement in the re Impacts more than or health status;4. Ur the resident, the Nurs will notify the resident (sponsor) when: b change in the resident psychosocial status A review of the facility January 2020, titled" " Prevention," revealed	telephone interview on ated when a new wound eport it to the UM, and he he doctor (Physician) and telephone interview on h, the Wound Consultants, ent #2's wound #1 was the point of contact . She said her initial ident #2 was on 11/5/2021, 2/13/2021. titled, "Change in Condition ision date of 6/29/2019 cy" included: "Our facility he resident, his or her and representative (sponsor) dent's medical/mental s (e.g., changes in level of Policy Interpretation and ded: "2. A "significant s a major decline or esident's status that:b. he area of the resident's ness otherwise instructed by e Supervisor/Charge Nurse 's family or representative b. There is a significant t's physical, mental, or ."	F	580				

Facility ID: NJ60407

If continuation sheet Page 6 of 25

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (DF DEFIC ENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		315280	B. WING			C 05/12/2022	
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
SILVER H	EALTHCARE CENTER				417 BRACE ROAD CHERRY HILL, NJ 08034		
(X4) ID PREFIX TAG				x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	Interventions to elimin will be introduced at t Interventions for pro- prevention of infection be initiated. Education staging, assessment pain management an modalities. The woun policy will be followed regimen is ordered by where there has been decline in a wound, a treatment will be cond included: "12. The p family/significant othe wound is discovered Under "Wound Care I "General Protocols"	hate or minimize risk factors he earliest possible time pomotion of healing and in to the extent possible will in will be provided to include of wound bed, infection, d prevention, and treatment d protocols included in this I unless another treatment y the physician. In cases in a lack of improvement of reassessment of the ducted." Under "Procedure," obysician and the er will be notified when a or if a would worsens" Protocol" included: NotifyFamily"	F	580			
	 be- (i) Developed within 7 the comprehensive as (ii) Prepared by an intincludes but is not lime (A) The attending phy (B) A registered nurse resident. (C) A nurse aide with resident. (D) A member of food 	Revision (i)-(iii) ensive Care Plans prehensive care plan must 7 days after completion of ssessment. terdisciplinary team, that nited to vsician. e with responsibility for the	F	657			6/17/22

Facility ID: NJ60407

If continuation sheet Page 7 of 25

	-	D HUMAN SERVICES MEDICAID SERVICES					FORM): 02/14/2023 MAPPROVED). 0938-0391
STATEMENT (DF DEFIC ENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	· /		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		315280	B. WING		C 05/12/2022			
NAME OF PI	ROVIDER OR SUPPLIER		- 1	S	TREET ADDRESS, CITY, STATE, ZIP CODE			
				14	417 BRACE ROAD			
SILVER H	EALTHCARE CENTER			с	HERRY HILL, NJ 08034			
(X4) ID PREFIX TAG	(EACH DEFIC ENC)	ATEMENT OF DEFIC ENCIES Y MUST BE PRECEDED BY FULL SC IDENT FY NG INFORMATION)	D PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COM CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
F 657	An explanation must I medical record if the p and their resident rep not practicable for the resident's care plan. (F) Other appropriate disciplines as determi or as requested by the (iii)Reviewed and revi team after each asses comprehensive and q assessments. This REQUIREMENT by: C#: NJ151116 Based on interviews, review of other pertine 5/10/2022 and 5/12/2 the facility failed to up (CP) for new wounds facility policies titled, ' Plans-Comprehensive Prevention" for 1 of 3 This deficient practice following:	esident's representative(s). be included in a resident's participation of the resident resentative is determined a development of the staff or professionals in ned by the resident's needs e resident. sed by the interdisciplinary assment, including both the uarterly review is not met as evidenced medical record review, and ent facility documents on 022, it was determined that date a Resident's Care Plan as well as failed to follow its	F	657	F 657 1. How the corrective action will b accomplished for those residents have been affected by the deficient practice: Based on interviews, medical reco review and review of other pertine facility documents, it was determined that facility failed to update the Reside Care Plan (CP) for new wounds for one (1) of (3) residents (Resident # 2). The residents is no longer at Silver Healthcare C	ords ent t this ent⊡s of thre reside Center	ee ent	
	According to the "Adn Resident #2 was adm ^{NJ Exec. Order 25 4.b.1} with diagr				An audit of all residents with press ulcers was conducted to identify a resident⊡s records needing a car update for pressure ulcers. 2. How the facility will identify othe residents having the potential to b affected by the	iny e plar er	ı	

Facility ID: NJ60407

		ID HUMAN SERVICES MEDICAID SERVICES				FO	ED: 02/14/2023 RM APPROVED IO. 0938-0391	
STATEMENT C	DF DEFIC ENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		315280	B. WING _			C 05/12/2022		
NAME OF PF	ROVIDER OR SUPPLIER	I	[S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 0		
				14	417 BRACE ROAD			
SILVER H	EALTHCARE CENTER			С	HERRY HILL, NJ 08034			
(X4) ID PREFIX TAG	(EACH DEFIC ENC	ATEMENT OF DEFIC ENCIES Y MUST BE PRECEDED BY FULL LSC IDENT FY NG INFORMATION)	D PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 657	Continued From page	e 8	F	657				
					same deficient practice:			
		mum Data Set (MDS), dated						
	7/7/2021, Resident #	. The			All residents have the potential of bein affected by this practice.	ng		
	MDS also showed Re	esident #2 needed ^{N Exec. Order 26:4.b.1}			 What measures will be put into plan systematic changes made to ensure the 			
					deficient practice will not return:			
	for Resident #2 dated Licensed Practical Nu	on/Re-admission Screener" 1 07/01/2021, written by the urse (LPN #1), indicated " 'NJ Exec. Order 26:4.b.1			DON/designee will provide retraining Nurses regarding updating of the care plan for any change in skin integrity.			
		d 10/8/2021 at 10:13 p.m. /ealed that the Aide reported 4.b.1			4. How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not reoccu	r:		
	wound team consulte	Will have the difference of			DON/designee will conduct weekly at of patient pressure ulcers to ensure th care	ne		
		#2's "Wound Report (WR)" N #1 revealed the resident lity acquired wounds:			plan is updated with each change in s integrity. This audit will continue for th (3) months or until compliance is achieve Monthly report of this process will be	ree		
	On 11/2/2021, Under Resident #2 had NJ E "Wound 2," indicated	"Wound 1" indicated xec. Order 26:4.b.1. Under Resident #2 had			provided to administration and a quar report will be reported to quality assurance performance improvement committee	·		
		"Wound 4" indicated Exec. Order 26:4.b.1 n 11/8/2021, and Under NJ Exec. Order 26:4.b.1 with no			one year.			

Facility ID: NJ60407

If continuation sheet Page 9 of 25

		D HUMAN SERVICES MEDICAID SERVICES					FORM	0: 02/14/2023 MAPPROVED 0. 0938-0391	
STATEMENT (DF DEFIC ENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	· /		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		315280	B. WING			_		C 12/2022	
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, ST	ATE, ZIP CODE	-		
SILVER H	EALTHCARE CENTER				417 BRACE ROAD				
	1				CHERRY HILL, NJ 0803				
(X4) ID PREFIX TAG	(EACH DEFIC ENC	ATEMENT OF DEFIC ENCIES Y MUST BE PRECEDED BY FULL SC IDENT FY NG INFORMATION)	D PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 657	Continued From page	9 9	F	657					
	On 11/30/2021, Unde NJ Exec. Order 26:4 on 11/8/2021.	r "Wound 5," revealed I.b.1							
	date of 12/14/2021 w	esident #2 with an effective ritten by UM/LPN #1 with a 2021 did not reveal any Resident #2.							
		Care Visit Report for /13/2021 ^{NJ Exec. Order 26:4.b.1} noted by the Wound d Practice Nurse (APN).							
	Under Focus: "(Resid revision on 09/26/202 "(Resident #2) has th	#2's Care Plan revealed ent #2) dated 11/22/2021 1 revealed Under Focus: e potential for skin #2) has ^{NJ Exec. Order 26:4.b.1}							
	to have skin intact thr date initiated 10/8/202 'NJ Exec. Order 26: initiated 08/22/20	021, "Assess skin for and report any changed to							
		ated 09/26/2021, ^{N Eec. Order 254,5} ate initiated 08/22/021, e initiated 8/22/2021, initiated 08/22/2021.							
	no documentation that	Resident #2's CP showed It the CP was updated with forementioned wounds.							
	During an interview o	n 5/10/2022 at 10:25 a.m.,							

Facility ID: NJ60407

If continuation sheet Page 10 of 25

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391			
STATEMENT (DF DEFIC ENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED			
		315280	B. WING			C 05/12/202				
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE					
				1	1417 BRACE ROAD					
SILVER H	EALTHCARE CENTER			C	CHERRY HILL, NJ 08034					
(X4) ID PREFIX TAG	(EACH DEFIC ENC	ATEMENT OF DEFIC ENCIES Y MUST BE PRECEDED BY FULL SC IDENT FY NG INFORMATION)	D PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE						
F 657	we do an incident rep doctor (physician), an (Interdisciplinary) tead discuss it, and put inter- continued to say the 0 myself or the Director floor nurse. During an interview of the DON stated the C time there is a change nurse who noticed the he/she writes the (nur- say there should be in a wound is found. The incident report. During a post-survey 5/12/2022 at 1:53 p.m a new wound, the nur- and the Unit Manager was updated. A review of the policy Plans-Comprehensive revealed Under "Polic of this facility to devel comprehensive care p includes measurable meet the resident's m psychological needs." included "3. The co- been designed to: and objectives in mea Prevent decline in the and/or functional lever (behavior manageme	ve identify a pressure ulcer, ort, notify the family and the ad meet as the IDT m, gather information, erventions in place. He CP would be updated by of Nursing (DON), not the n 5/12/2022 at 11:00 a.m., iP should be updated every e, and the CP is done by the e change that day when rse) note. She continued to neident reports for each time e Wound report is not the telephone interview on n., LPN#1 stated if there was rse could update the CP, r would make sure the CP titled "Care e" with a date of 01/05 cy" included: "It is the policy op an individual and olan for each resident which objectives and timetables to redical, nursing and	F	657						

Facility ID: NJ60407

If continuation sheet Page 11 of 25

		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 02/14/2023 MAPPROVED). 0938-0391	
STATEMENT O	DF DEFIC ENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:		PLE CONSTRUCTION	-	(X3) DATE SURVEY COMPLETED		
		315280	B. WING			C 05/12/2022		
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE			
SILVER HI	EALTHCARE CENTER			1417 BRACE ROAD CHERRY HILL, NJ 080	34			
(X4) ID PREFIX TAG	(EACH DEFIC ENC)	ATEMENT OF DEFIC ENCIES Y MUST BE PRECEDED BY FULL .SC IDENT FY NG INFORMATION)	D PREFIX TAG	(EACH CORRE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD BI ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 657	thereafter. Care plans as changes in the res Any changes in the the staff and any outs appropriate" A review of the facility January 2020, titled "Policy," included: "It assess for the risk of pressure ulcers or oth Interventions to elimin will be introduced at t Interventions for pro- prevention of infection be initiated. Education staging, assessment pain management and modalities. The woun policy will be followed regimen is ordered by where there has been decline in a wound, a	irst quarter, and quarterly a are reviewed and updated ident's condition dictates8 a plan are communicated to ide sources when policy with a revised date of Wound Care and the following: Under is the policy of the facility to and the presence of her skin alterations. The earliest possible time bomotion of healing and in to the extent possible will n will be provided to include of wound bed, infection, d prevention, and treatment d protocols included in this unless another treatment of the physician. In cases in a lack of improvement of reassessment of the ducted." Under "Wound Care General Protocols"	F 65	57				
F 686 SS=D	CFR(s): 483.25(b)(1)(§483.25(b) Skin Integ §483.25(b)(1) Pressu	event/Heal Pressure Ulcer (i)(ii) rity	F 68	36			6/17/22	

Facility ID: NJ60407

If continuation sheet Page 12 of 25

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED . 0938-0391	
STATEMENT (DF DEFIC ENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	· · /		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		315280	B. WING			C 05/12/2022		
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	-	
SILVER H	EALTHCARE CENTER				417 BRACE ROAD HERRY HILL, NJ 08034			
(X4) ID PREFIX TAG				D PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHO TAG CROSS-REFERENCED TO THE APP DEFICIENCY)			(X5) COMPLETION DATE	
F 686	resident, the facility m (i) A resident receives professional standard pressure ulcers and c ulcers unless the indi- demonstrates that the (ii) A resident with pre- necessary treatment is with professional star- promote healing, prev- new ulcers from deve This REQUIREMENT by: C#: NJ151116 Based on interviews a record and other perti 5/10/2022 and 5/12/2 the facility failed to pr resident was consistent and provided bowel a care as well as failed "Policy: Charting and "Wound Care and Pre- residents (Resident # was evidenced by the A review of Resident follows: According to the "Adm Resident #2 was adm "Uter Order 204.043" with diagno- Disorder.	aust ensure that- e care, consistent with s of practice, to prevent loes not develop pressure vidual's clinical condition ey were unavoidable; and essure ulcers receives and services, consistent idards of practice, to vent infection and prevent loping. ' is not met as evidenced and review of the medical nent facility documents on 022, it was determined that ovide evidence that a intly turned and repositioned ind bladder incontinence to follow its policies titled Documentation" and evention" for 1 of 3 sampled 2). This deficient practice e following: #2's Medical Record was as	F	686	F 686 1. How the corrective action will be accomplished for those residents found have been affected by the deficient practice: Based on the record review and interviews and reviews of pertinent documents, the facility failed to provide evidence that the resident was consistently turned and repositioned and provided bowel and bladder incontinence care as well as documenting and charting and wound care prevention for one (1) of three (3) sampled resident (Resident #2). The resident is no longer Silver Healthcare Center. An audit of a residents with pressure ulcers or its potential (BRADEN scale) was conducted to identify any residents in need of turning and repositing, bowel and bladder incontinence care.	he on nts er at		

Facility ID: NJ60407

If continuation sheet Page 13 of 25

	-	ID HUMAN SERVICES MEDICAID SERVICES			FORM	D: 02/14/2023 MAPPROVED D. 0938-0391
STATEMENT (DF DEFIC ENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		315280	B. WING		C 05/12/2022	
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	
			14	417 BRACE ROAD		
SILVER H	EALTHCARE CENTER		с	HERRY HILL, NJ 08034		
(X4) ID PREFIX TAG	(EACH DEFIC ENC)	ATEMENT OF DEFIC ENCIES Y MUST BE PRECEDED BY FULL .SC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 686	admitted without wou A review of "Admissic for Resident #2 dated Licensed Practical Nu Under "Skin Integrity, Re no pressure wounds. A review of the "Brade Pressure Sore Risk C #2 indicated Braden S on 7/1/2021 with a sco 7/13/2021 with a sco revealed Resident #2 A review of Progress 10/8/2021 at 10:13 p. revealed that the Aide Will h consulted for any reco A review of PNs dated written by LPN #1 rev noted with NJ Exec. C	2 had ^{NJ Exec. Order 26:4.b.1} . The sident #2 ^{NJ Exec. Order 26:4.b.1 and was nds. n/Re-admission Screener" 7/01/2021, written by the urse (LPN #1), indicated " NJ Exec. Order 26:4.b.1 sident #2 was admitted with en Scale for Predicting Original" form for Resident Scales done on admission ore of "^{NTER}" and on e of "^{NTER}"; both scores was ^{NJ Exec. Order 26:4.b.1 Notes (PNs) dated m. written by LPN #2 e reported ^{NJ Exec. Order 26:4.b.1} Notes (PNs) dated m. written by LPN #2 e reported ^{NJ Exec. Order 26:4.b.1} ave the wound team ommendations. d 11/2/2021 at 9:21 p.m. ealed that Resident #2 was Order 26:4.b.1}}	F 686	 2. How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected by this deficient practice. 3. What measures will be put into place systematic changes made to ensure the deficient practice will not return: DON/designee will provide retraining the all nurses and CNAs regarding turning and reposition, as well as provision of bowel and bladder incontinence care. 4. How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not reoccur DON/designee will conduct weekly autof patient pressure ulcers or its potent (BRADEN score) to assure that the residents are being appropriately turniand repositioned as well bowel and bladder incontinence care and its documentation of the procedures in the resident s record. The audit will continue for three (3) months until compliance is achieved. Monthly report of this process will be provided to administration and a quart report. 	nat coo g dits ial ed er on Fhis s or	
	with MD (physician) a				-	

Event ID: 285611

Facility ID: NJ60407

If continuation sheet Page 14 of 25

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT OF DEFIC ENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:					E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		315280	B. WING			C 05/12/2022	
NAME OF PF	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
	EALTHCARE CENTER			1	417 BRACE ROAD		
	EALIHOARE CENTER			C	CHERRY HILL, NJ 08034		
(X4) ID PREFIX TAG	(EACH DEFIC ENC)	ATEMENT OF DEFIC ENCIES Y MUST BE PRECEDED BY FULL SC IDENT FY NG INFORMATION)	D PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 686	Continued From page A review of the "Wour Resident #2 with an e written by the Unit Ma Nurse (UM #1) with a revealed under "Wour had NJ Exec. Order 1 management. A review of WR for Re date of 11/2/2021 writ date of 11/8/2021 reve indicated Resident #2 Manage A review of WR for Re date of 11/9/2021 writ date of 11/9/2021 reve indicated Resident #2 with the following inter management and Uno Resident #2 had NJ E	e 14 Ind Report (WR)" for effective date of 11/2/2021 Inager/Licensed Practice signed date of 11/8/2021 Ind 1" showed Resident #2 26:4.b.1 esident #2 with an effective ten by UM #1 with a signed ealed Under "Wound 2" had a NJ Exec. Order 26:4.b.1 ment. esident #2 with an effective ten by UM #1 with a signed vealed under "Wound 4" had NJ Exec. Order 26:4.b.1 Inventions: NJ Exec. Order 26:4.b.1 fiventions: NJ Exec. Order 26:4.b.1 fiventions: NJ Exec. Order 26:4.b.1 ith no documented date and h the following interventions:		686	DEFICIENCY)		
	A review of WR for Re	esident #2 with an effective itten by UM #1 with a signed					

If continuation sheet Page 15 of 25

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391		
STATEMENT	OF DEFIC ENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED		
		315280	B. WING			C 05/12/2022			
NAME OF P	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	-		
SILVER H	EALTHCARE CENTER				1417 BRACE ROAD CHERRY HILL, NJ 08034				
(X4) ID PREFIX TAG	(EACH DEFIC ENC	ATEMENT OF DEFIC ENCIES Y MUST BE PRECEDED BY FULL SC IDENT FY NG INFORMATION)	D PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE		
F 686	date of 11/30/2021 re NJ Exec. Order 26:4 n 1 interventions: NJ Exec an At the time of the sum Reports before Nover provided. A review of a "Docum (DSR)" form used for tasks for Resident #2 Reposition every 2 ho 7/31/2021 revealed b the task was not docu 7/2/2021, 7/15/2021, 7/29/2021 and 7/30/2 p.m. shift; on 7/4/202 7/11/2021, 7/16/2021 7/23/2021, 7/16/2021 a.m3:00 p.m. shift. A review of the DSR f documented as follow and 7/13/202 on the on 7/2/2021, 7/15/202 on the 3:00 p.m11:0 7/6/2021, 7/10/2021, 7/20/2021, 7/21/2021 on the 7:00 a.m3:00 A review of the DSR f	vealed Under "Wound 5," a 4.b.1 1/8/2021 with the following c. Order 26:4.b.1 nagement. vey, Wound Consultant Visit mber 2021 were not entation Survey Report ADL documentation of to be Turned and ours dated 7/1/2021 through lank spaces which indicated umented as follows: on 7/22/2021, 7/25/2021, 021 on the 3:00 p.m11:00 1, 7/6/2021, 7/10/2021, 7/20/2021, 7/21/2021, and 7/29/2021 on the 7:00 form used for ADL ks, Bladder Continence gh 7/31/2021 revealed blank ed the task was not vs: on 7/1/2021, 7/9/2021, 11:00 p.m7:00 a.m. shift; 21, 7/22/2021 and 7/25/2021 0 p.m. shift; on 7/4/2021, 7/11/2021, 7/16/2021, 7/11/2021 and 7/29/2021 p.m. shift.	F	686					

Facility ID: NJ60407

If continuation sheet Page 16 of 25

		D HUMAN SERVICES				FORM	APPROVED 0. 0938-0391	
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFIC ENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENT FICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		315280	B. WING			C 05/12/2022		
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE	-		
SILVER H	EALTHCARE CENTER				1417 BRACE ROAD CHERRY HILL, NJ 08034			
(X4) ID PREFIX TAG	(EACH DEFIC ENC	ATEMENT OF DEFIC ENCIES Y MUST BE PRECEDED BY FULL .SC IDENT FY NG INFORMATION)	D PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 686	revealed blank space was not documented 7/9/2021, 7/13/2021 o shift; on 7/2/2021, 7/1 7/25/2021 on the 3:00 7/4/2021, 7/6/2021, 7 7/16/2021, 7/20/2021 7/29/2021 on the 7:00 A review of a DSR for documentation of task every 2 hours dated 8 revealed blank space was not documented 8/12/2021, 8/13/2021 on the 7:00 a.m3:00 8/8/2021, 8/21/2021, 8/29/2021 and 8/31/2 p.m. shift. A review of the DSR f documentation of task dated 8/1/2021 throug spaces which indicate documented as follow 11:00 p.m 7:00 a.m 8/21/2021, 8/23/2021 the 3:00 p.m11:00 p 8/8/2021, 8/12/2021, 8/24/2021 and 8/29/2 p.m. shift. A review of the DSR f documentation of task dated 8/12/2021, 8/23/2021 the 3:00 p.m11:00 p 8/8/2021, 8/12/2021, 8/24/2021 and 8/29/2 p.m. shift.	s which indicated the task as follows on: 7/1/2021, on the 11:00 p.m7:00 a.m. 5/2021, 7/22/2021 and 0 p.m11:00 p.m. shift; on /10/2021, 7/11/2021, , 7/21/2021, 7/25/2021 and 0 a.m3:00 p.m. shift. m used for ADL (s to Turn and Reposition 8/1/2021 through 8/31/2021 s which indicated the task as follows: on 8/7/2021, , 8/14/2021 and 8/29/2021 p.m. shift; on 8/7/2021, 8/23/2021, 8/27/2021, 021 on the 3:00 p.m11:00 form used for ADL (s, Bladder Continence gh 8/31/2021 revealed blank ed the task was not vs: on 8/26/2021 on the .; on 8/7/2021, 8/8/2021, , 8/27/2021, 8/29/2021 on .m. shift; on 8/7/2021, 8/13/2021, 8/14/2021, 021 on the 7:00 a.m3:00	F	686				

Facility ID: NJ60407

If continuation sheet Page 17 of 25

	-	ID HUMAN SERVICES				FORM	APPROVED 0. 0938-0391	
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:					E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED	
		315280	B. WING			C 05/12/2022		
NAME OF P	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE			
SILVER H	EALTHCARE CENTER				1417 BRACE ROAD CHERRY HILL, NJ 08034			
(X4) ID PREFIX TAG	(EACH DEFIC ENC	ATEMENT OF DEFIC ENCIES Y MUST BE PRECEDED BY FULL SC IDENT FY NG INFORMATION)	D PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE	
F 686	8/29/2021 and 8/31/2 shift; on 8/7/2021, 8/8 8/13/2021, 8/14/2021 on 7:00 a.m3:00 p.m. A review of a DSR for documentation of tasl every 2 hours dated 9 revealed blank space was not documented 9/28/2021 on the 11:0 9/4/2021, 9/9/2021, 9 9/17/2021, 9/19/2021 9/17/2021, 9/19/2021 9/19/2021, 9/25/2021 p.m11:00 p.m. shift. 9/12/2021, 9/13/2021 9/19/2021, 9/20/2021 a.m3:00 p.m. shift. A review of DSR form documentation of tasl dated 9/1/2021 throug spaces which indicate documented as follow 9/23/2021 and 9/28/2 a.m. ; at 3:00 p.m11 9/9/2021, 9/10/2021, 9/19/2021, 9/10/2021, 9/19/2021, 9/11/2021 9/25/2021 and 9/29/2 on 9/9/2021, 9/11/2021 9/28/2021. A review of the DSR f documentation of tasl Movements dated 9/1 revealed blank space was not documented	021 on 3:00 p.m11:00 p.m. 8/2021, 8/12/2021, , 8/24/2021 and 8/29/2021 h.shift. The used for ADL ks to Turn and Reposition 9/1/2021 through 9/30/2021 s which indicated the task as follows on 9/21/2021 and 00 p.m7:00 a.m. shift; on /10/2021, 9/11/2021, , 9/21/2021, 9/23/2021, and 9/29/2021 on the 3:00 ; on 9/9/2021, 9/11/2021, , 9/16/2021, 9/18/2021, and 9/28/2021 on the 7:00 In used for ADL ks, Bladder Continence gh 9/30/2021 revealed blank ed the task was not vs on 9/4/2021, 9/21/2021, 021 on the 11:00 p.m7:00 :00 p.m. on 9/4/2021, 9/11/2021, 9/17/2021, , 9/23/2021, 9/24/2021, 021; at 7:00 a.m3:00 p.m. 21, 9/12/2021, 9/20/2021 and	F	686				

Facility ID: NJ60407

If continuation sheet Page 18 of 25

	-	ID HUMAN SERVICES				FORM	D: 02/14/2023 MAPPROVED D. 0938-0391	
STATEMENT (OF DEFIC ENCIES F CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PL A. BUILDING		(X3) DATE SURVEY COMPLETED			
		315280	B. WING			C 05/12/2022		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE			
SILVER H	EALTHCARE CENTER			1417 BRACE ROAD CHERRY HILL, NJ 0803	34			
(X4) ID PREFIX TAG	(EACH DEFIC ENC)	ATEMENT OF DEFIC ENCIES Y MUST BE PRECEDED BY FULL LSC IDENT FY NG INFORMATION)	D PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 686	11:00-7:00 a.m. shift; 9/10/2021, 9/11/2021 9/21/2021, 9/23/2021 9/29/2021 on the 3:00 9/9/2021, 9/11/2021, 9/16/2021, 9/18/2021 9/28/2021 on the 7:00 A review of a DSR for documentation of task every 2 hours dated 1 10/31/2021 revealed indicated the task was on 10/3/2021 on the 7 on 10/2/2021, 10/3/20 10/8/2021, 10/9/2021 10/22/2021, 10/28/20 p.m11:00 p.m. shift; 10/12/2021, 10/14/20 10/29/2021, 10/30/20 7:00 a.m3:00 p.m. s A review of the DSR f documentation of task dated 10/1/2021 through blank spaces which in documented as follow on the 11:00 p.m7:0 10/3/2021, 10/16/202 10/28/2021 and 10/28 -11:00 p.m. shift; on 1 10/12/2021, 10/14/201 10/17/2021, 10/14/202	on 9/4/2021, 9/9/2021, , 9/17/2021, 9/19/2021, , 9/24/2021, 9/25/2021 and 0 p.m11:00 p.m. shift and 9/12/2021, 9/13/2021, , 9/19/2021, 9/20/2021 and 0 a.m3:00 p.m. shift. rm used for ADL ks to Turn and Reposition 10/1/2021 through blank spaces which s not documented as follows 11:00 p.m7:00 a.m. shift; 021, 10/4/2021, 10/17/2021, , 10/16/2021, 10/17/2021, 21, 10/29/2021 on the 3:00 ; on 10/3/2021, 10/8/2021, 21, 10/15/2021, 10/16/2021, 21, 10/22/2021, 10/26/2021, 21 and 10/31/2021 on the shift. form used for ADL ks, Bladder Continence ugh 10/31/2021 revealed ndicated the task was not vs on 10/3/2021, 10/27/2021 00 a.m. shift; on 10/2/2021, , 10/17/2021, 10/8/2021, 1, 10/17/2021, 10/26/2021, 21, 10/15/2021, 10/16/2021, 21, 10/15/2021, 10/16/2021, 21, 10/15/2021, 10/16/2021, 21, 10/15/2021, 10/16/2021, 21, 10/15/2021, 10/26/2021, 21, 10/15/2021, 10/26/2021, 21, 10/31/2021 on the shift.	F 686	3				

Facility ID: NJ60407

If continuation sheet Page 19 of 25

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 02/14/2023 MAPPROVED D. 0938-0391
STATEMENT (OF DEFIC ENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		315280	B. WING				C 1 2/2022
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
SILVER H	EALTHCARE CENTER			14 C			
(X4) ID PREFIX TAG	(EACH DEFIC ENC)	ATEMENT OF DEFIC ENCIES Y MUST BE PRECEDED BY FULL SC IDENT FY NG INFORMATION)	D PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686	documentation of task Movements dated 10/ revealed blank space was not documented and 10/27/2021 on the shift; on 10/2/2021, 1 10/7/2021, 10/8/2021 10/17/2021, 10/8/2021 10/15/2021, 10/8/2021 10/15/2021, 10/16/20 and 10/31/2021 on the A review of a DSR for documentation of task every 2 hours dated 1 11/30/2021 revealed k indicated the task was follows: on 11/1/2021 11/10/2021, 11/13/202 and 11/19/2021 on the on 11/1/2021, 11/13/202 and 11/27/2021 on the A review of the DSR f documentation of task dated 11/1/2021 throu blank spaces which in documented as follow 11:00 p.m7:00 a.m. 11/2/2021, 11/5/2021, 11/3/2021, 11/5/2021, 11/3/2021, 11/5/2021,	ks, Bowel Continence, and /1/2021 through 10/31/2021 s which indicated the task as follows: on 10/3/2021 e 11:00 p.m7:00 a.m. 10/3/2021, 10/4/2021, 10/9/2021, 10/16/2021, 21, 10/9/2021, 10/16/2021, 21, 10/17/2021, 10/20/2021, 21, 10/17/2021, 10/20/2021, 21, 10/17/2021, 10/20/2021 e 7:00 a.m3:00 p.m. shift. m used for ADL ks to Turn and Reposition 11/1/2021 through blank spaces which s not documented as , 11/2/2021, 11/5/2021, 21, 11/14/2021, 11/15/2021 e 3:00 p.m11:00 p.m. shift; 021, 11/5/2021, 11/9/2021, 21, 11/18/2021 11/23/2021 e 7:00 a.m3:00 p.m. shift. form used for ADL ks, Bladder Continence ugh 11/30/2021 revealed ndicated the task was not vs: on 11/29/20211 on the shift; on 11/1/2021, 21 and 11/19/2021 on the shift; on 11/1/2021, 21 and 11/19/2021 on the shift; on 11/1/2021, 21 and 11/27/2021 on the	F	686			

If continuation sheet Page 20 of 25

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT (DF DEFIC ENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:				(X3) DATE COMP	SURVEY PLETED	
315280 NAME OF PROVIDER OR SUPPLIER			B. WING			C 05/12/2022		
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		-	
SILVER H	EALTHCARE CENTER				417 BRACE ROAD HERRY HILL, NJ 08034			
(X4) ID PREFIX TAG	(EACH DEFIC ENC	ATEMENT OF DEFIC ENCIES Y MUST BE PRECEDED BY FULL SC IDENT FY NG INFORMATION)	D PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE	
F 686	A review of the DSR f documentation of tasl Movements dated 11/ revealed blank space was not documented 11/2/2021, 11/5/2021, 11/14/2021, 11/15/2021, 11/14/2021, 11/23/2021, 11/18/2021, 11/23/2021, 7:00 a.m3:00 p.m. s A review of a DSR for documentation of tasl every 2 hours dated 1 12/31/2021 revealed indicated the task was follows: on 12/4/2021 p.m11:00 p.m. shift; 12/10/2021 and 12/12 p.m. shift. A review of the DSR f documented as follow and 12/13/2021 on th on 12/4/2021 and 12/ p.m11:00 p.m. shift; and 12/12/2021 on th A review of the DSR f documented as follow and 12/13/2021 on th on 12/4/2021 and 12/ p.m11:00 p.m. shift; and 12/12/2021 on th A review of the DSR f documentation of tasl Movements dated 12, revealed blank space was not documented and 12/12/2021 on th	form used for ADL ks, Bowel Continence, and (1/2021 through 11/30/2021) s which indicated the task as follows: on 11/1/2021, (11/10/2021, 11/13/2021, 21) and 11/19/2021 on the shift; on 11/1/2021, (11/9/2021, 11/14/2021, 21) and 11/27/2021 on the hift. m used for ADL ks to Turn and Reposition (2/1/2021 through) blank spaces, which s not documented as and 12/12/2021 on the 3:00 on 12/3/2021, 12/7/2021, (2/2021 on the 7:00 a.m3:00) form used for ADL ks, Bladder Continence ugh 12/31/2021 revealed holicated the task was not (x): on 12/2/2021, 12/7/2021, e 11:00 p.m7:00 a.m. shift; 12/2021 on the 3:00 on 12/3/2021, 12/7/2021 e 7:00 a.m3:00 p.m. shift.	F	686				

Facility ID: NJ60407

If continuation sheet Page 21 of 25

		ID HUMAN SERVICES MEDICAID SERVICES					FORM): 02/14/2023 MAPPROVED). 0938-0391
STATEMENT (OF DEFIC ENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	· /		CONSTRUCTION		(X3) DATE COMF	SURVEY LETED
		315280	B. WING			_		C 12/2022
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
SILVER H	EALTHCARE CENTER				417 BRACE ROAD HERRY HILL, NJ 0803	4		
(X4) ID PREFIX TAG	(EACH DEFIC ENC	ATEMENT OF DEFIC ENCIES Y MUST BE PRECEDED BY FULL .SC IDENT FY NG INFORMATION)	D PREFIX TAG		PROVIDER'S (EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA		(X5) COMPLETION DATE
					[DEFICIENCY)		
F 686	Continued From page the 7:00 a.m3:00 p.r		F 6	86				
	the aforementioned d every 2 hours, Bladde	ocumentation provided for ates to Turn and Reposition er Continence and Bowel ements for Resident #2 at 7.						
		ident #2's MR showed no valuations after the Resident nentioned wounds.						
	the Certified Nursing , she remembered Res turns and repositions, 2 hours. The CNA co was documented in th the surveyor showed DSR form, the CNA c	n 5/12/2022 at 9:53 a.m., Assistant (CNA) stated that sident #2, and she, the Aide, moves the Resident every ntinued to say it (the task) he kiosk plan of care. When her the blank spaces on the ontinued to say, "I don't spaces mean; I never saw by."						
	the Director of Nursin Resident #2 would ge order for turning and would do the turning a document on the kios she didn't know what the ADL sheet; she w	n 5/12/2022 at 11:00 a.m., g (DON) stated that et out of bed. There is no repositioning. The CNAs and repositioning care and k. The DON further stated the blank spaces meant on ould clarify with the Unit ractice Nurse (UM/LPN).						
	the presence of the D showed the UM/LPN spaces for Resident # blanks (spaces) mean	\$2, the UM/LPN stated the						

Facility ID: NJ60407

If continuation sheet Page 22 of 25

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 02/14/2023 APPROVED D. 0938-0391
	OF DEFIC ENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	` '				LETED
		315280	B. WING				C 12/2022
NAME OF P	ROVIDER OR SUPPLIER	-		ST	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
SILVER H	EALTHCARE CENTER				417 BRACE ROAD HERRY HILL, NJ 08034		
(X4) ID PREFIX TAG	(EACH DEFIC ENC)	ATEMENT OF DEFIC ENCIES Y MUST BE PRECEDED BY FULL SC IDENT FY NG INFORMATION)	D PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686	it wasn't documented, done? The UM/LPN fr not documented, it is During the same inter a.m., when the survey documentation on the stated the CNAs do A focus charting. She co ADL charting policy; t "Charting and Docum charting for nurses. Th had a change in wour explained in July that consultant, and at the a lapse in wound care co November. She contin of the Wound Consult for Resident #2. During an interview of when the surveyor as Braden Scale Assess she stated that Reside Braden Score/Scale co During an interview of the UM stated no othe in the MR for Resident During a post-survey 5/13/2022 at 9:44 a.m Nurse Practitioner (NI causes ulceration and 12/14/2021, the wound	, does it mean it wasn't urther stated, "I agree if it is not done." view on 5/12/2022 at 11:25 yor asked about the CNA a DSR forms, the DON DLs, and the nurse does ontinued to say there is no he only Policy is the uentation" based on focus he DON further stated we nd care (consultants). She there was one wound care e end of October, there was e consultants, then the onsultants came in nued to say she gave me all tant Visit Reports she had n 5/12/2022 at 12:33 p.m., ikked the DON about the ment Tool for Resident #2, ent #2 should have a done for every skin change. n 5/12/2022 at 1:00 p.m., er Braden Scale forms were	F 6	\$86			

Facility ID: NJ60407

If continuation sheet Page 23 of 25

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391	
STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:					E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED	
		315280	B. WING			C 05/12/2022		
NAME OF P	ROVIDER OR SUPPLIER	L	- I	S	STREET ADDRESS, CITY, STATE, ZIP CODE		-	
SILVER H	EALTHCARE CENTER				1417 BRACE ROAD CHERRY HILL, NJ 08034			
(X4) ID PREFIX TAG	(EACH DEFIC ENC	ATEMENT OF DEFIC ENCIES Y MUST BE PRECEDED BY FULL SC IDENT FY NG INFORMATION)	D PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 686	During a post-survey 5/17/2022 at 2:39 p.m Nurse (APN) from the for Resident #2's NJ E	telephone interview on h., the Advanced Practice Wound Consultants stated Exec. Order 26:4.b.1	F	686	;			
	and Documentation" under "Policy" include facility that each reside record which is a con- care, response to car- progress of the reside for identification and c and friends will be inco- complete history of th current law and regular resident's admission."	ility policy titled "Charting revealed the following: ed "It is the policy of this lent will have a clinical cise account of treatment, e, signs, symptoms and ent's condition. Data needed communication with family cluded. It will also include a re resident as required under ations at the time of						
	of January 2020, title Prevention," revealed "Policy," included: "It assess for the risk of pressure ulcers or oth Interventions to elimin will be introduced at t Interventions for pro- prevention of infection be initiated. Education staging, assessment pain management an	l the following: Under is the policy of the facility to and the presence of						

Facility ID: NJ60407

If continuation sheet Page 24 of 25

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 02/14/2023 APPROVED 0. 0938-0391	
STATEMENT	DF DEFIC ENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED C		
		315280	B. WING		_		_ 12/2022	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE			
SILVER H	EALTHCARE CENTER			417 BRACE ROAD CHERRY HILL, NJ 0803	34			
(X4) ID PREFIX TAG	(EACH DEFIC ENC	ATEMENT OF DEFIC ENCIES Y MUST BE PRECEDED BY FULL LSC IDENT FY NG INFORMATION)	D PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 686	regimen is ordered by where there has been decline in a wound, a treatment will be cond included: "1. The Bra- standard research-ba tool. The Braden scal admission, re-admiss significant change in resident will be repos educated as needed weight at a minimum individually assessed toileting programs wil individually assessed investigation will be c acquired wounds. 14.	I unless another treatment y the physician. In cases a lack of improvement of reassessment of the ducted." Under "Procedure," den scale will be the used screening/assessment e will be completed on ion, quarterly, and when a status occurs5. The itioned or reminded and/or to reposition or shift their of every 2 hours or as 7. Incontinent care and/or I be implemented as 13. An incident report and ompleted on all in-house .All wounds will be ing office on the weekly ing and trending and facility iew"	F 686					

Facility ID: NJ60407

If continuation sheet Page 25 of 25

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION		DATE OF REVISIT	
IDENTIFICATION NUMBER	A. Building			
315280 _{Y1}	B. Wing	Y2	6/23/2022	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE		
SILVER HEALTHCARE CENTER		1417 BRACE ROAD		
		CHERRY HILL, NJ 08034		

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEN	M	DATE	ITEM		DATE	ITEM		DATE
Y4		Y5	Y4		Y5	Y4		Y5
ID Prefix Reg. # LSC	F0580 483.10(g)(14)(i)-(iv)(15) Completed 06/23/2022	ID Prefix Reg. # LSC	F0657 483.21(b)(2)(i)-(iii)	Correction Completed	ID Prefix Reg. # LSC	F0686 483.25(b)(1)(i)(ii)	Correction Completed 06/23/2022
ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC		Correction Completed
ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC		Correction Completed
ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC		Correction Completed
ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC		Correction
REVIEWEI STATE AG REVIEWEI CMS RO FOLLOWU 5/12/2022		REVIEWED BY (INITIALS) REVIEWED BY (INITIALS) DMPLETED ON		SIGNATURE OF TITLE CK FOR ANY UNCORREC DRRECTED DEFICIENCI				es 🗌 no