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 _____	05/29/2019

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

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F 000	INITIAL COMMENTS SURVEY DATE: 05/29/19 CENSUS: 200 SAMPLE SIZE: 35 The facility is not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for long term care facilities.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the	F 578		7/31/19

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

Electronically Signed | 07/01/2019

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F 578	Continued From page 1 requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that an advance directive was obtained for 2 of 35 residents (Resident #114 and #154) reviewed for advance directives. This deficient practice was evidenced by the following: 1. On 05/16/19 at 09:30 AM, during the initial tour of the facility, the surveyor observed Resident #114 in the bed with eyes open. The resident was waiting for the Certified Nurses Aide for morning care. Review of the the quarterly Minimum Data Set (MDS), an assessment tool dated [redacted] which showed the resident had a brief interview of mental status of [redacted] The resident's functional status was a two person physical assistance for bed mobility, a one person physical assistance for dressing and a set up only for eating. Medical	F 578	1. - Resident #114 was admitted to the facility under services of [redacted]. was placed in the medical file to follow. Nursing staff was in-serviced on [redacted] guidelines in order to follow. Staff was following [redacted] directives in providing care and making decisions. - Resident #154 was educated about different choices regarding legal documents for medical decision making, including Advanced Directives vs POLST form. Resident expressed desire to have POLST form instead of Advanced Directives that was introduced to the resident for completion. 2. All residents having the potential to be affected by the same deficient practice.	

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F 578	Continued From page 2 diagnosis include [redacted] On 05/21/19 at 1:28 PM, the surveyor conducted a paper chart review for an advance directive and could not locate one. The surveyor then reviewed the electronic medical record and could not locate an advance directive. On 05/21/19 at 1:35 PM, the surveyor interviewed the resident regarding advance directives and the resident stated he/she was not asked about advance directives. On 05/21/19 at 1:50 PM, the surveyor interviewed the Unit Licensed Practical Nurse (LPN) regarding an advance directive for the Resident #114 and the LPN stated the resident did not have one and could not provide any more information. On 05/28/19 at 09:39 AM, the surveyor reviewed the facility's Advance Directive Policy and it reflected that the facility's process for advance directives was the social worker would introduce the POLST (Physician orders for Life Sustaining Treatment) form to the family or representative on admission to the facility and the form will be "identified" for the physician's signature. On 05/28/19 at 09:59 AM, the surveyor interviewed the social worker regarding an advance directive for the resident. The social worker stated that "usually [redacted] are full codes, but we can talk to the [redacted]	F 578	3. - Social Services Director/Designee will complete full audit of all medical records to identify and complete any missing legal documents for medical decision making. - Newly admitted residents, if not having legal documents for medical decision making upon admission, will be educated about such in order to complete desired document for medical decision making if needed. - Social Services staff will be in-serviced on importance of having/completing legal documents for medical decision making for all residents in timely manner in accordance with CMS guidelines and State Law . 4. - DON/Designee will conduct audits of 10 randomly selected medical records to ensure that legal document for medical decision making are completed and filed into the medical record. -Social Services Director/Designee will conduct audits to ensure that all newly admitted residents have legal documents for medical decision making in the medical file. - 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 meeting for review and revision as deemed appropriate.	

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F 578	Continued From page 3 2. On 05/16/19 at 10:11 AM, the surveyor observed Resident #154 in bed eating breakfast. Review of the resident's quarterly MDS, dated [redacted], showed Resident #154 had a Brief Interview of Mental Status of [redacted] The resident's functional status for bed mobility, toilet use, and transfer was a two person physical assist. Medical diagnoses included [redacted]. On 05/20/19 at 12:47 PM, the surveyor conducted a record review and could not locate an advance directive or a POLST form. On 05/20/19 at 12:55 PM, the surveyor interviewed the resident regarding advance directives and the resident said he/she were never asked about them. On 05/21/19 at 01:38 PM, the surveyor interviewed the Registered Nurse Unit Manager (RN/UM) regarding the advance directive. The RN/UM attempted to locate an advance directive and stated the resident didn't have one. On 05/28/19 at 10:20 AM, the surveyor reviewed the initial social services assessment and Section B under subtitle "legal" was an advance directive area and the area was left incomplete.	F 578		
F 584 SS=E	NJAC 8:39-4.1 (a) 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,	F 584		7/31/19

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F 584	Continued From page 4	F 584		

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);

§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:

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F 584	Continued From page 5 Based on observation, interview and record review, it was determined that the facility failed to maintain residents' environment and equipment in good repair and in good sanitary condition. This deficient practice was identified in multiple residents' rooms throughout the [redacted] and [redacted] Units, and for Residents #79, #77, #196, and #150, and was evidenced by the following: During the initial facility tour from 05/16/19 11:40 AM to 12:30 PM, the surveyor inspected the resident rooms on the [redacted] Unit and noted the following: 1. In room [redacted], the surveyor observed a broken cove base on the wall by the entrance to the bathroom. 2. In room [redacted], the night stand's top drawer had a missing handle. The resident was not able to be interviewed. 3. In room [redacted], by the bathroom entrance, the vent cover was broke and was hanging loose from wall. There was a bedside table with a rusted metal base. The bedside table also had partially detached, dangling molding around the table top, exposing the interior substrate. The cove base on the wall between bed A and bed B was detached from the wall, with an exposed area at the bottom of the wall that was covered with a brown and dark substance. 4. In room [redacted], the cove base near bed A was loose and partially detached from the wall. The room chair was soiled and covered in dirt and dark stains.	F 584	1. - Room [redacted]- cove base was repaired immediately and the room chair was replaced. - Room [redacted] - night stand was changed to a new one immediately. - Room [redacted] - the vent cover was fixed, bedside table was replaced, cove base was repaired. - Room [redacted] - door was fixed immediately. - Room [redacted] - window blind was replaced, string for overhead light was fixed, sink faucet was replaced, mirror above the sink was placed, toilet lid was replaced. Room [redacted] - tube feeding pole was cleaned, wall socket cover and wall around were fixed, the positioning wedge was replaced, bedside table was replaced. - Resident #150's bilateral wheelchair armrests were replaced. - Resident #5's bilateral bed rail pads were replaced. - Room [redacted] was cleaned, stripped and waxed. - Room [redacted] - walls were repaired and window blinds were replaced. - All staff were in-serviced in importance of identifying/reporting/recording all maintenance/housekeeping issues into the maintenance log that locates at each nursing unit. 2. All residents having the potential to be affected by the same deficient practice. 3. - All Department Heads/Unit Managers will complete routine rounds of assigned	

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F 584	Continued From page 6 5. In room [redacted], the door dragged on the floor and made a squeaking noise as the surveyor tried to open the door. 6. In room [redacted], the bottom blade of the window blind was broken in half. There was no string attached to the overhead light above the bed A, to allow for turning on and off the light. The surveyor interviewed the certified Nursing Assistant (CNA) who was in room 413 at the time. The CNA inspected the overhead light and acknowledged he could not turn on the light due to no string. He did not provide an explanation for why the string was not fixed. 7. In the bathroom in room [redacted], the sink had continuously running water that could not be turned off. At 12:12 PM, the CNA was unsuccessful in his attempt to turn the faucet off. The mirror above the bathroom sink was missing. The toilet lid was also missing. 8. In room [redacted], the tube feeding pole, used for the resident in bed B, had dirt, debris and a dried brown substance at the base of the pole. The area around the wall socket was broken, behind bed A's head board. The positioning wedge on bed A's bed was ripped. There was a bedside table in the room, which had rusted metal area. On 05/16/19 at 12:29 PM, the surveyor and the Registered Nurse Unit Manager (RN/UM), returned to each room to observe the above areas. At that time, the RN/UM confirmed the findings and stated that staff were supposed to notify him if they see a problem or they were to write it in the log book. The RN/UM showed the surveyor a log book for maintenance and after	F 584	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. - All staff will be routinely in-serviced on identifying/reporting/recording maintenance/housekeeping issues into the maintenance log. 4. - Administrator/Designee will conduct random audits of the rooms through daily rounds. - All Department Heads/Unit Managers will 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 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.	

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F 584	Continued From page 7	F 584		

reviewing the log book in the presence of the surveyor, he stated the above listed areas were not in the log book.

On 05/16/19 at 12:54 PM, the surveyor interviewed the Maintenance Director (MD) who stated that each nursing station had a 3-ring binder in which they are to record broken equipment or anything needing repair. The Maintenance Director stated his staff checked the binder throughout the day. He went on to say that if the repair requires parts that are in stock, maintenance typically completes the repair the same day. However, if the part is not in stock, the repair will occur once the part is received. The RN/UM, who was present during the interview with Maintenance Director, stated staff were to report issues and broken equipment when they see them.

On 05/16/19 at 1:02 PM, the surveyor interviewed the unit CNA assigned to room [redacted]. She stated the cove base had been detached for a while. The CNA added she was supposed to report it to the RN/UM or write it in the maintenance log book located at the nurses' station. The CNA also stated she did not write or report the broken cove base or the broken bedside table and that she was usually more focused on the residents care.

On 05/17/19 at 11:03 AM, the surveyor noted the mirror above the sink was still missing in room [redacted] bathroom.

9. On 05/17/19 at 11:07 AM, the surveyor observed Resident #150 seated in a wheelchair with bilateral armrests that were ripped. The surveyor made this same observation on 05/22/19 at 1:30 PM, while the resident was in the

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F 584	Continued From page 8	F 584		

day room. At that time, the surveyor and the RN/UM observed the armrests. The RN/UM acknowledged the torn armrests but did not provide further information for why armrests were not repaired.

10. On 05/20/19 at 09:15 AM, during the medication pass observation for Resident #5, the surveyor observed the resident's bilateral bed rail pads was ripped and shredded along the length of the pads. The surveyor interviewed the resident's CNA, and the resident's nurse on 05/20/19 at 10:05 AM who both stated they did not report the bed rail pads and acknowledged the pads needed to be changed.

On 05/20/19 at 10:10 AM, the surveyor interviewed the RN/UM for the unit, who stated she was not aware of the ripped pads and that she expected staff to report broken equipment.

The surveyor reviewed the cleaning schedules for the [redacted] Unit, which showed the staff should spot clean all rooms, check supplies, clean immediate concerns upon arrival to duty.

During an interview with facility administration on 0 5/23/19 at 11:30 AM, the Administrator stated that staff were all in-serviced during their annual in-service, and should know to report broken equipment or write it in the maintenance log book.

2. On 05/16/19 at 9:40 AM, during the tour of the [redacted] Unit, in room [redacted] the surveyor observed the floor was sticky with a 5 foot area of black marks.

On 05/16/19 at 11:30 AM, in room [redacted] the surveyor observed peeling walls, buckled wall

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F 584	Continued From page 9 paper on the wall behind the residents bed, and broken blinds. The resident stated the blinds had been broken since admission. There were also multiple areas of missing paint noted on all of the walls in the room.	F 584		
F 698 SS=D	NJAC 8:39-4.1 (a) Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to complete dialysis communication forms following dialysis treatments. This deficient practice was identified for Resident #106 and Resident #10, 2 of 3 residents reviewed for [redacted] and was evidenced by the following: 1. On 5/16/19 at 09:35 AM, on initial tour of the facility the surveyor observed the resident sitting in the room in a wheelchair with eyes open. The resident told the surveyor that he/she was a [redacted] patient and had an [redacted]). Review of Resident #106's admission Minimum Data Set (MDS), an assessment tool dated [redacted], showed that the resident had a Brief Interview of Mental Status (BIMS) score of [redacted]	F 698	1. - [redacted] Residents #106 and #10's medical records were audited to insure that access assessment was documented and any order were transcribed and carried out. - Nursing staff were in-serviced on completing [redacted] communication form upon resident's return from [redacted] treatment. 2. Residents who receive [redacted] treatment having potential to be affected by the same practice. 3. - All medical records of the residents on [redacted] audited to ensure access assessment was documented and any order were transcribed and carried out.	7/31/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 698	Continued From page 10 meaning the resident was [redacted] The resident's functional status was a one-person physical assist for transfers and bed mobility, and a one person physical assist for locomotion on the unit. Medical diagnosis included [redacted] On 05/21/19 at 11:13 AM, the surveyor reviewed the resident's [redacted] communication records (form). The form accompanies the resident to [redacted] and is used to communication information about the resident between the facility and the [redacted] center. The form consisted of three areas. The first area was to be completed by the facility's licensed nurse for a [redacted] patient prior to [redacted] and included the resident's vital signs (blood pressure and temperature), [redacted], time of last meal, diet, and general condition. The second area was to be completed by the [redacted] center following the [redacted] treatment and included [redacted], pre and post [redacted] weights, new orders/significant change in condition during [redacted], and medications administered during the [redacted] treatment. The third area was to be completed by the facility's licensed nurse when the resident returned from [redacted] and included [redacted] new orders from [redacted], and a signature/date line indicated the nurse who received the resident following the [redacted]	F 698	- All nursing staff were in-serviced in completing [redacted] communication form upon return from [redacted] 4. - DON/Designee will conduct audits of [redacted] communication forms to ensure that all forms are fully completed. - 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.	

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F 698	Continued From page 11	F 698		

treatment.

Review of the May 2019 forms revealed that seven of the seven forms were blank in the third area that was to be completed by the receiving nurse on the resident's unit. The dates that the forms were incomplete were 05/18/19, 05/16/19, 05/14/19, 05/11/19, 05/09/19, 05/07/19, and 05/04/19.

On 05/21/19 at 11:17 AM, the surveyor interviewed the unit Licensed Practical Nurse (LPN) regarding the communication forms and [redacted] documentation. The LPN stated that they check the resident's [redacted] for a [redacted] even though the forms were blank. The LPN stated the [redacted] were monitored every shift and documented on the Treatment Administration Record (TAR) but not always at the time the resident returned from [redacted]. The surveyor then interviewed the Unit Manager who stated that the forms should be filled out and the staff will need to be educated.

2. On 05/16/19 at 12:39 PM, during the initial tour of the facility, Resident #10 was in bed with eyes open. The resident told the surveyor that he/she attends [redacted] three times weekly in the building. The resident had a [redacted]

Review of the resident's quarterly MDS, dated [redacted] showed the resident had a BIMS of [redacted] The resident's functional status was independent with dressing and eating and a supervision for locomotion on the unit. Medical

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 _____	05/29/2019

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

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F 698	Continued From page 12 [redacted] Review of the May 2019 forms showed that section three of the forms were blank on 05/20/19, 05/17/19, 05/06/19, 05/03/19, and 05/01/19. There was also an undated form that was not completed. On 05/21/19 at 10:40 AM, the surveyor interviewed the resident's LPN. The LPN stated the [redacted] were monitored every shift and documented on the Treatment Administration Record (TAR) but not always at the time the resident returned from [redacted]. The surveyor interviewed the Unit Manager who stated that the forms should be completed, and he/she would instruct the nursing staff. Review of the facility's [redacted] Care Guidelines section III, titled Documentation, revealed that when a resident attends [redacted] Communication Record will be completed by the nurse.	F 698		
F 761 SS=D	NJAC 8:39-2.9 Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when	F 761		7/31/19

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 _____	05/29/2019

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F 761	Continued From page 13 applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to a.) store medications and biologicals in locked rooms and compartments that permit only authorized personnel to have access, and b.) remove expired medications from the medication storage cabinet where other current use medications were stored. This deficient practice was identified for 2 of 3 medication rooms (med rooms) inspected and was evidenced by the following: 1. On 05/16/19 at 1:46 PM, the surveyor observed a room which was located in a non-residential area close to a general service hallway near the kitchen and other offices and conference room. The surveyor entered the room	F 761	1. - Medical Supply Room door lock was replaced from passage lock to store room lock that locks automatically. - The sign stating that door must stay locked at all times was placed. - Nursing staff were in-serviced on keeping the supply room locked at all times. - The expired medication was discarded immediately. - Nursing staff were in-serviced on discarding expired medications from the med room according to provided expiration date. 2.All residents having potential to be affected by the same deficient practice.	

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	315280	A. BUILDING _____ B. WING _____	05/29/2019

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F 761	Continued From page 14 which was closed but unlocked. Inside the room, the surveyor observed boxes of medical supplies. The surveyor noted a second door inside the first room. The door was closed and unlocked. The surveyor entered the room and observed the shelves which were filled with different types of over-the-counter medications. In addition, the room contained a standing metal cabinet which had a broken lock system, allowing access to the cabinet. The surveyor opened the cabinet and observed boxes of different sizes of injection needles and syringes. On 05/16/19 at 1:50 PM, the surveyor accompanied the Director of Nursing (DON) to the medication room that was located inside the storage room. The DON confirmed that the medication room and the syringe/needle cabinet were unlocked. During an interview at that time, the DON stated the room was for the storage of stock medication and medical supplies and that the doors and cabinet should be maintained locked. The DON stated he was not sure who left the doors unlocked and then locked all the doors. 2. On 05/17/19 at 10:11 AM, the surveyor inspected the medication room on the [redacted] Unit in the presence of the Registered Nurse Unit Manager and observed one pack of unopened [redacted] which expired on 8/2018. There was also another 10-pack box of [redacted] that expired on 10/2018. On 05/17/19 at 10:26 AM, the surveyor interviewed the Registered Nurse Unit Manager (RN/UM) and showed him the expired medications. He removed the medications from the cabinet. When questioned about the process of checking the medication room and who was	F 761	3. - Nursing staff will insure that medical supply doors are locked at all times. - Nursing staff will discard all expired medications according to the manufacturer expiration date daily. - Facility will continue to utilize an audit check list for the medication room that night Supervisor will continue to complete weekly. - Pharmacy consultant will continue to complete medication room audits monthly. - Nursing staff will be in-serviced on discarding expired medications from the medication room according to the provided expiration date. 4. - DON/Designee will conduct weekly medication room audits and record result to the audit sheets to ensure that all expired medications are removed from the medication storage before expiration. - DON/Designee will conduct routine audits to ensure that medical supply room is locked at all times. - 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.	

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	315280	A. BUILDING _____ B. WING _____	05/29/2019

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F 761	Continued From page 15 responsible, he stated the pharmacist consultant checked the medication rooms monthly. He later provided a document titled: Monthly Medication storage and security checklist. The checklist reflected the medication room was inspected on 05/10/19 by the nurse. The RN/UM could not say why the expired medications had been left in the cabinets. On 05/23/19 at 11:30 AM, both the Administrator and the Director of Nursing stated that nursing staff were responsible for checking the medication room to ensure expired medications were removed from the cabinet. NJAC 8:39-29.2 (c)	F 761		
F 812 SS=D	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.	F 812		7/31/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 812	Continued From page 16 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to monitor, and discard expired refrigerated food. This deficient practice was evidenced by the following: On 05/16/19 at 10:10 AM, the surveyor, in the presence of the Food Service Director (FSD), observed three 48-ounce plastic tubes of ricotta cheese, all dated with a used by date of 5/13/19, in the reach-in refrigerator. The FSD acknowledged that they were expired and then discarded the tubes. The surveyor reviewed the policy and procedure for food storage with a revised date of 01/17/19, which indicated that all refrigerated food will be checked to assure that foods will be consumed by their safe used by date or discarded. On 05/23/19, the Administrator was made aware of the surveyor's finding. NJAC 8:39 - 17.2 (g)	F 812	1. - Three 48-ounce plastic tubes of ricotta cheese were discarded immediately. - Kitchen staff were in-serviced on safe food handling practices. 2. All residents having the potential to be affected by the same deficient practice. 3. - All refrigerated food will be checked to assure that foods will be consumed by their safe used by date or discarded. - Kitchen staff will be in-serviced on safe food handling practices. 4. - FSD/Designee will place monitoring system/audits to ensure all refrigerated food received and stored in a manner that complies with safe food handling practices. - 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.	
F 880 SS=F	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	F 880		7/31/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 880	Continued From page 17	F 880		

development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control 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.

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SILVER HEALTHCARE CENTER	1417 BRACE ROAD CHERRY HILL, NJ 08034

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F 880	Continued From page 18 (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct 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 infection control practices that minimize the potential for cross-contamination identified for 1 of 2 residents (Resident #75) reviewed for transmission-based precautions; 1 of 5 residents (Resident #36) observed during the medication pass; and during laundry processing. This deficient practice was evidenced by the following: 1. According to the admission record, Resident #175 was admitted to the facility on [redacted] with medical diagnosis which included [redacted]	F 880	1. - LPN #1 was re-educated on isolation precaution guidelines and proper use of PPE for the isolated residents while on isolation. - All nursing staff were re-educated on medication pass and infection control protocols. - All nursing staff were re-educated on proper removal of the soiled linen, separating of soiled linen from personals and placing the bags to the designated area for the soiled linen in order to prevent cross-contamination. - All nursing staff were re-educated on not putting trash in the soiled linen room. - Laundry staff were re-educated on	

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F 880	Continued From page 19 [redacted] According to the admission Minimum Data Set (MDS), an assessment tool dated [redacted], Resident #175 had a Brief Interview for Mental Status (BIMS) score of [redacted] Review of the care plan, dated initiated on 04/22/19 and revised on 04/26/19, reflected Resident #175 was on isolation with contact precautions for [redacted] e On 05/20/19 at 12:08 PM, the surveyor observed a treatment cart in front of resident #175's room. The room door was closed. There was a stop sign and a cart to the side of the doorway with personal protective equipment (PPE) in the cart. The surveyor observed the Licensed Practical Nurse (LPN) #1 open the door and exit the room with gloved hands and a protective mask on his face. Without removing the gloves, the LPN removed equipment from the cart with no protective gown and then returned to the room and closed the door. The surveyor then observed a Certified Nursing Assistant (CNA) open the door, from the inside, and stood in the doorway	F 880	proper handling of the soiled linen and personals to prevent cross-contamination. - All linen bins were labeled based on purpose of the bin: clean linen vs. soiled linen in order to prevent cross-contamination. - All laundry staff were in-serviced on using marked bins only based on the label on them; clean linen - for clean and soiled linen - for soiled. - All laundry staff were in-serviced on usage of PPE, proper handwashing, transmission-based precautions while handling soiled linen in the laundry room, and cleaning/disinfecting of the bins and carts. - Eye wash mount station was fixed immediately. - Laundry staff were in-serviced on importance of identifying/reporting/recording of maintenance issues into the maintenance log book. - Laundry staff were in-serviced that all chemicals and cleaning agents must be stored in labeled containers. 2. All residents having the potential to be affected by the same deficient practice. 3. - All nursing staff will be in-serviced on medication pass and infection control protocols. - Nursing competencies on medication pass will be completed for all nurses. - All nursing staff will be in-serviced on proper removal of the soiled linen, separating of soiled linen from personals	

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F 880	Continued From page 20 wearing a yellow protective gown. She then removed her PPE at the doorway. The CNA stated she was from an agency and the resident was on contact isolation. The surveyor then observed a Licensed Practical Nurse (LPN) #2 donning a protective yellow gown and gloves. Before she entered the room, LPN #2 stated that Resident #175 was on contact isolation. She then called into the room for LPN #1 to come to the doorway, at which time both LPN #1 and LPN #2 acknowledged that LPN #1 should have been wearing a gown in the room. LPN #1 stated the resident was on contact isolation and that a protective gown should be worn. On 05/20/19 at 12:50 PM, the surveyor interviewed the Registered Nurse Unit Manager (RN/UM) who stated that the resident was on contact isolation and when entering and caring for the resident, staff should wear a protective gown and gloves. On 05/23/19 at 11:46 AM, the Administrator and DON were notified of the findings. Review of the facility's Isolation-Categories of Transmission-Based Precaution policy, with a revised date of 1/2019, revealed that when a resident is on contact precautions staff must remove gloves before exiting the room and a disposable gown should be worn before entering the room. According to the employee's file and orientation packet, LPN #1 was hired on [redacted] and received infection control and blood borne pathogen education.	F 880	and placing the bags to the designated area for the soiled linen in order to prevent cross-contamination. - All nursing staff will be in-serviced on not putting trash in the soiled linen room. - Laundry staff will be in-serviced on proper handling of the soiled linen and personals to prevent cross-contamination. - All linen bins will be used according to the provided labeling; clean linen bin - for clean linen and soiled linen bin - for soiled linen in order to prevent cross-contamination. - All laundry staff will be in-serviced on using marked bins based on the label provided; clean linen - for clean and soiled linen - for soiled. - All laundry staff will use appropriate PPE while handling soiled linen. - All laundry staff will follow a proper handwashing protocol, transmission-based precautions while handling soiled linen in the laundry room, and cleaning/disinfecting of the bins and carts after the use. - All laundry staff will be in-serviced on usage of PPE, proper handwashing, transmission-based precautions while handling soiled linen in the laundry room, and cleaning/disinfecting of the bins and carts after use. - All laundry staff will use an eye wash station when needed. - Laundry staff will utilize a maintenance log book to report maintenance issues in the laundry room. - Laundry staff will be in-serviced on importance of identifying/reporting/recording of	

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	315280	A. BUILDING _____ B. WING _____	05/29/2019

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F 880	Continued From page 21 2. During the medication pass observation on [redacted] Unit on 05/21/19 at 9:55 AM, the surveyor observed a nurse knock over Resident #36's medicine cup which caused one pill to fall out of the cup and onto the open Medication Administration Record that was on top of the medication cart. The nurse picked up the tablet with her bare, uncleansed hands and placed it back into the medicine cup, along with other medications in the cup, and administered them to Resident #36. When questioned about the facility protocol regarding infection control during med pass, the nurse did not provide an explanation for why she touched the pill with her bare, uncleansed hands. 3. During a tour of the [redacted] Unit on 05/16/19 at 11:36 AM, the surveyor observed a Certified Nurse Aide (CNA #2) walking in the hallway while tying the top of a clear plastic bag that contained trash. CNA #2 placed the bag in the soiled linen room, located next to room [redacted]. At that time, CNA #2 stated that this [linen room] is where he sometimes put the trash, even though the room is for linen only. On 05/16/19 at 11:38 AM, Licensed Practical Nurse (LPN #2) accompanied the surveyor to the [redacted] Unit's soiled linen room, located near room [redacted] In the room, there were clear plastic bags, containing personal clothes and linens, observed in a large, over-filled, blue bin and also on the floor in front of the bin. Some of the linen bags contained a mix of both personal clothing and facility linens. Also, on the floor were clear plastic bags of trash that were next to and in direct contact with bags of linen. A sign posted on the wall in the soiled linen room read, "All trash is	F 880	maintenance issues into the maintenance log book. - Laundry staff will properly label and store all chemicals and cleaning agents. - Laundry staff will be in-serviced that all chemicals and cleaning agents must be stored in labeled containers. 4. - ADON/Designee will conduct routine audits of nursing competencies on medication pass. - DON/Designee will complete routine rounds/audits to insure proper removal of the soiled linen, separating soiled linen from personals, placing the bags to the designated area for the soiled linen and not putting trash in the soiled linen room in order to prevent cross-contamination. - Environmental Director/Designee will conduct routine rounds/audits on proper handling of the soiled linen and personals to prevent cross-contamination. - Environmental Director/Designee will conduct routine rounds/audits of linen bins to ensure that they used according to the placed labeling; clean linen bin - for clean linen and soiled linen bin - for soiled linen in order to prevent cross-contamination. - Environmental Director/Designee will conduct audits on laundry staff following proper handwashing protocol, transmission-based precautions while handling soiled linen in the laundry room, and cleaning/disinfecting of the bins and carts after the use. - Environmental Director/Designee will conduct audits on staff utilizing a maintenance log book to report	

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	315280	A. BUILDING _____ B. WING _____	05/29/2019

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F 880	Continued From page 22 to be placed in the trash and labeled 'Hazardous Waste' across from the activity room. No trash is to be placed in the soiled linen room." During an interview at that time, LPN #2 confirmed these findings and stated that trash was not supposed to be in the room. She also stated that the facility processes their own laundry but was unsure of the laundry schedule. She explained that some times the residents' clothing are mixed in with the linen when bagged. However, the clothing is labeled and gets sorted in the laundry room prior to laundering. On 05/16/19 at 11:50 AM, laundry staff (Staff #1) was observed wheeling a large, unlabeled, gray bin into the [redacted] Unit's soiled linen room, located near room [redacted]. Staff #1 removed some of the bags from the blue bin and placed them in the gray bin. At that time, Staff #1 acknowledged that there were mixed bags of laundry and stated, "the nurses don't always separate them." Staff #1 stated that the facility processes all linens and resident personal clothing. He added that laundry is picked up every two hours for linens and personal clothing is picked up during the night. During a subsequent interview on 05/17/19 at 1:00 PM, Staff #1 stated the laundry was picked up every three hours. On 05/16/19 at 12:03 PM, in the presence of the Director or Nursing (DON), the surveyor observed the soiled linen room, located next to the nourishment room in the [redacted] Unit, [redacted] Upon entry, the surveyor noted the room was strongly malodorous. There was a large blue bin that contained un-bagged personal clothing that was soiled with a caked-on, brown-colored substance. Also, in the bin and in direct contact	F 880	maintenance issues in the laundry room. - Environmental Director/Designee will audit proper labeling and storage all chemicals and cleaning agents. - 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.	

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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 23	F 880		

with the soiled un-bagged clothing, was a clear plastic bag of mixed linen and personal clothing.

During an interview at that time, the DON stated that the room should not look like this and that all clothing and linens should be separated and contained in bags. The DON pointed out that the sign posted on the wall indicated that clothing should be bagged and not just placed in the bin.

On 05/17/19 at 12:30 PM, the surveyor toured the laundry room, in the presence of Staff #1. Upon inquiry of where soiled laundry would be rinsed, Staff #1 stated, that the laundry is not rinsed or separated. He stated, the laundry is "just thrown right into the washer." He clarified that if they notice personal clothing in with the linens, they will try to separate before washing.

During that time, the surveyor noted that there were several large gray and blue bins in the laundry room. The bins were not labeled to indicate whether they were for soiled or clean laundry. Staff #1 stated that the blue bins are for clean linen and the gray are for soiled. When asked if a blue bin was ever used for soiled, Staff #1 stated sometimes. When asked if the bins are disinfected, Staff #1 stated that it is done occasionally and that there is no routine or log kept. He indicated to a clear, plastic, fluid-filled, un-labeled bottle, hanging by the trigger from the shelving unit and stated they use bleach to clean the bins. Staff #1 confirmed that the liquid in the container was bleach that was left over from the 35 pound container of bleach used in the laundry. At that moment, a laundry staff member (Staff #2) entered the laundry room and attempted to remove a blue bin that was in front the driers. Staff #2 stated he was going to pick up soiled

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 _____	05/29/2019

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 24	F 880		

linen. Staff #2 was halted by Staff #1 who informed Staff #2 to use the gray bin. Staff #1 then stated that Staff #2 was new.

On 05/17/19 at 1:10 PM, a laundry staff member (Staff #3) was observed opening plastic bags of laundry from a gray bin and then placing the soiled linens into the front-loading washer. Staff #3 was wearing a short-sleeve shirt and gloves. When placing the soiled linen into washer, he stuffed the linens into the washer in such a way that his bare forearms were in contact with the linens. After emptying the gray bin, Staff #3 placed it aside, without spraying or disinfecting. He then removed his gloves and proceeded to the sink to wash his hands. Using soap and water, he washed his hands appropriately but did not wash his forearms. Also, sitting in the sink during handwashing was the eye wash hose. The eye wash hose did not have caps. Staff #3 stated that the eye wash hose mount broke a long time ago and always sits in the sink. Staff #3 then exited the laundry room.

On 05/17/19 at 1:17 PM, the surveyor interviewed Staff #1, Staff #2 and Staff #3 on infection control policies and procedures. Staff #1 stated he has been at the facility for over a year and that nobody told him how to wash his hands, "we just know to do it." Staff #1 stated that he may have been told during orientation but has never done a handwashing competency. Staff #2 stated he has been at the facility since February 2019. He recalls being told how to wash his hands during orientation. He stated, "it's like 60 seconds or something." Staff #2 stated he had not done a handwashing competency that he is aware of. When asked about wearing gowns when handling soiled linen, Staff #1 indicated to the protective

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 _____	05/29/2019

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 25	F 880		

gowns stored on the shelving unit and stated they do not wear gowns because "it is too hot down here." Staff #1 went on to say that sometimes he will wear it on the night shift if the soiled linen "really smells." Staff #2 and Staff #3 agreed with Staff #1's statement regarding gown use.

On 05/17/19 at 3:35 PM, in the presence of the Administrator, the surveyor interviewed the Director of Housekeeping and Laundry (DHL) who stated that he was contracted staff and that the laundry staff were employed by the facility. He stated that he is responsible for both housekeeping and laundry services. The DHL acknowledged that the blue and gray bins are not clearly marked to designate what bins are used for soiled and clean, and they should be. He also confirmed that there is no process in place for the routine cleaning of the bins. The DHL stated there have been no in-services "in a while" for handwashing, personal protective equipment, and transmission-based precautions. Upon request, the DHL was unable to provide in-service records. The DHL and Administrator stated that there are no records. The DHL acknowledged that the eye wash mount was broken and that the hose has been sitting in the sink for a while. The Administrator asked the DHL if he reported it to maintenance to be fixed, and the DHL replied, "no." The DHL stated that the laundry staff should not have transferred the laundry bleach to the bottle and that the bottle should have labeled for content.

A review of the "CMS Laundry Operation Manual," revised March 2016, revealed the following:
The "General Laundry Procedures" document reflected that after soiled linen has been removed, spray bins or carts with disinfectant

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 _____	05/29/2019

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 26 cleaner. Under the Sorting Soiled Linen heading, it indicated to always wear gloves and a protective gown when sorting soiled linen. Never allow soiled linen to come in contact with your person. Disinfect any bins used to deliver soiled linen to laundry. Under the Loading Washing Machine heading, it indicated to always wear gloves and gown when loading a washing machine. Under the Handwashing Techniques heading, it reflected to apply soap thoroughly... rub hands together rapidly for 10 seconds... Under Safety in the Laundry, the laundry area should be designed and operated so that work flow and paths for transporting clean and soiled linen are separate to prevent cross-contamination. Food and beverages are strictly prohibited from being consumed or stored in the laundry area. Under the Chemicals and Cleaning Agents heading, it indicated that all chemicals and cleaning agents must be stored in labeled containers. Under the infection control procedures, it indicated, never cross contaminate clean and soiled linen. Bins are to be clearly marked for clean or soiled line and used accordingly. Never use bins for both clean and soiled linen. NJAC 8:39-19.4(a)2	F 880		
F 881 SS=F	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program	F 881		7/31/19

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 _____	05/29/2019

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 881	Continued From page 27 that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to follow protocols and the Antibiotic Stewardship Program. This deficient practice was identified for Residents #46, #133, and #149, 3 of 6 residents reviewed for the Antibiotic Stewardship Program and was evidenced by the following: 1. According Resident #133's progress notes, the resident was on receiving [redacted] services and on 01/31/19, the [redacted] nurse documented that the resident was exhibiting behaviors, had [redacted]. The Physician was notified, and the resident was placed on [redacted] twice daily for 7 days for a [redacted]. Review of Resident #133's quarterly Minimum Data Set (MDS), an assessment tool dated [redacted], showed the resident's Brief Interview of Mental Status (BIMS) could not be conducted because the resident was [redacted] The resident's functional status was a two-person physical assistance for transfers, dressing and toileting. Medical diagnoses included [redacted] Review of the resident's Minimum Criteria for Initiation of Antibiotics in Long Term Care Residents (a form the facility used to assess	F 881	1. - Nursing staff will fill out SBAR tool before initiation of any antibiotic (AB) therapy for the residents with suspected infection at once. - All SBAR's will be submitted to Infection Preventionist (IP) for review and tracking. - Antibiotic Stewardship Program (ASP) team will meet with infection disease MD, to initiate further steps to follow facility ASP protocol as well as to schedule monthly ASP meetings. - If criteria is questionable, IP will contact infection disease MD to seek consult. Any provided recommendations, if any, will be conveyed to attending physician to follow. - IP will utilize ASP tracking tool as a monitoring system that aggregates AB use data and provides feedback to the prescribers. - ASP tracking tool will be submitted with Infection Disease MD for review/analysis weekly. - ASP team revised ASP Policies and Procedures to insure compliance with CMS and State regulations on ASP. - All nursing staff in-serviced on ASP and use of SBAR tool for initiating AB therapy. 2. All residents with suspected infections having the potential to be affected by the same deficient practice. 3. - Nursing staff will follow antibiotic	

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 _____	05/29/2019

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

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F 881	Continued From page 28 criteria prior to starting residents on antibiotics), dated 09/26/18, revealed there were no criteria circled on the form [redacted] The form also reflected the following: On 09/26/18, the resident's [redacted] requested the [redacted] and [redacted] was ordered. On 09/27/18, it was documented that the resident was in no distress. On 09/28/18, it was documented the resident's temperature was 97.9. On 10/03/18, it was documented the resident completed the antibiotic course, no lab work, [redacted], and that the resident did not meet criteria for antibiotics. 2. On 05/16/19 at 10:30 AM, during the initial tour of the [redacted] Unit, the surveyor observed Resident #46 seated in a wheelchair and self propelling around the unit. According to the Admission Record, Resident #46 was originally admitted to the facility on [redacted] with diagnoses that included; [redacted] Review of the quarterly MDS, dated [redacted], indicated that the resident's BIMS score was [redacted] Review of the resident's Minimum Criteria for	F 881	stewardship guidelines to insure to meet minimum criteria for initiation of AB therapy in long-term care utilizing appropriate SBAR for meeting the criteria. - ASP team will meet with Infection Disease MD to initiate further steps to follow facility ASP protocol. - IP will utilize ASP tracking tool to analyze and recognize trends. - All nursing staff, MD's and APN's will be in-serviced on ASP and use of SBAR tool for initiating AB therapy. 4. - IP/Designee will complete ASP tracking tool monthly to report results/trends at monthly QAPI meetings. - IP/Designee will conduct routine audits to ensure that nursing staff complete SBAR as communication tool for any residents with suspected infection. - 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 _____	05/29/2019

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

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F 881	Continued From page 29	F 881		

Initiation of Antibiotics in Long Term Care Residents form, dated 05/19/18, revealed the criteria was highlighted for [redacted], which was productive cough (without fever). The back of the form had handwritten notes that read; slight productive cough, N/O (new order) [redacted] x 10 days for [redacted]. Afebrile (absence of fever), Asymptomatic (no symptoms) besides slight cough. APN (Advanced Nurse Practitioner) contacted continue ABT (antibiotic) despite no lab work, no chest x-ray. Course completed.

Review of the Physician's Orders, dated 05/18/18, revealed a handwritten order for [redacted] (antibiotic) by mouth twice daily for 10 days for [redacted]

3. On 05/16/19 at 10:30 AM, during the initial tour of the [redacted] Unit, the surveyor observed Resident #149 seated in a wheelchair in a common area with a [redacted] on the resident's [redacted] and write. The resident did not want to talk to the surveyor.

According to the Admission Record, Resident #149's was originally admitted to the facility on [redacted] with diagnoses that included; [redacted]

Review of the Significant Change MDS, dated [redacted], revealed the resident's BIMS score was [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 _____	05/29/2019

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 881	Continued From page 30	F 881		

Review of the resident's Minimum Criteria for Initiation of Antibiotics in Long Term Care Residents, dated 09/02/18, reflected their were no criteria circled. The form revealed the following hand written note: "9/2 complained of back pain/nausea, [redacted] sent to the ER by [redacted] for [redacted]. Returned back with a New Order for [redacted] by mouth TID (three times a day) X 5 days. No discomfort [redacted]. Temp 97.5 9/11 complained of [redacted] Course Completed. No Indication of ABT need."

On 05/29/19 at 10:55 AM, the surveyor interviewed the [redacted] LPN #2 regarding the protocol for antibiotic use. LPN #2 stated that if a resident has symptoms of an infection the nurse would make the doctor or the APN aware of the resident's symptoms. The doctor or the APN would order lab work and possibly an x-ray, and a decongestant if the symptoms were respiratory. The nurse would then notify the doctor or APN when the lab, and or x-ray results were completed. The surveyor asked LPN #2 would an antibiotic be ordered for a resident if lab work, or x-rays were not ordered? LPN #2 replied, "no that would not happen, the doctor or APN would not do that."

On 05/29/19 at 12:13 PM, the surveyor interviewed and reviewed the Minimum Criteria for Initiation of Antibiotics in Long Term Care form with the ADON, who is also the Infection Control Nurse. The ADON stated it was her responsibility to follow up with the residents who were prescribed antibiotic therapy. The surveyor reviewed the handwritten notes on the back of the forms with the ADON and she stated, "Those are my notes. I review the physician orders, lab

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 _____	05/29/2019

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 881	Continued From page 31	F 881		

results, x-ray results, physician and nursing progress notes. This is a brief summary of my findings." The surveyor asked the ADON who would follow up with a physician if an antibiotic was ordered without an indication for need. The ADON stated "most likely the Unit Manager."

A review of the facility's Antibiotic Stewardship Program, dated 01/01/19, reflected that the facility would use SBAR (Situation, Background, Assessment, Recommendation), a technique that can be used to facilitate prompt and appropriate communication, for any residents with a suspected [redacted]). The surveyor requested the SBAR from the ADON and she stated that the facility was not using them at this time, but they planned to begin.

Review of the Antibiotic Stewardship Program (ASP) binder, that was supplied by the Administrator, contained information regarding the ASP plan and designation of leadership and responsibilities of the ASP team. The Mission Statement and Leadership Commitment Antibiotic Stewardship Program document (Leadership and team) was signed and dated by the Administrator on 01/08/19 and by the DON and Infection Prevention (IP) Coordinator on 01/04/19. The document indicated the members of the Antibiotic Stewardship Team (AST) would meet quarterly and the members listed included the medical director, ADON/IP Coordinator, DON, nursing management team, a nurse practitioner, and the consulting pharmacist.

Review of the quarterly compliance meetings (Antibiotic Stewardship Agenda) revealed that the meetings were held on 01/31/18, 04/27/18, 07/30/18, and 10/30/18. The agenda does

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 _____	05/29/2019

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 881	Continued From page 32	F 881		

indicate there was involvement by the medical director, nurse practitioner and consultant pharmacist. There was no documentation of quarterly ASP meetings in 2019; however, infection control data was included in the 2019 monthly quality assurance meetings.

On 05/16/19 at 3:09 PM, the surveyor interviewed the IP Coordinator regarding the ASP quarterly compliance meetings who stated the quarterly meeting have not been held since 2018 and there have not been any meetings in 2019. She confirmed that the medical director, consultant pharmacist and nurse practitioner had not attended the 2018 meetings. The IP Coordinator added that there are morning meetings that are used to discuss antibiotic/infections of residents and that the consultant pharmacist and medical director do not attend the morning meetings. Additionally, the IP Coordinator stated that the facility used the Loeb minimum criteria for initiating antibiotic therapy; however, the Loeb criteria form was used after the antibiotic was started as a means to evaluate if the antibiotic should have been given. She stated there are no written antibiotic use protocols currently in place to ensure best practices. She also explained that the medical director used to be involved when the ASP was first established but because of the informal nature, she is not involved any more. She stated that there were no other physicians involved in looking at the antibiotic use and that is was difficult to get the physician or nurse practitioners to discontinue antibiotic treatments, even when the Loeb criteria was not met. The IP Coordinator also stated that they currently do not have a monitoring system in place that aggregates antibiotic use data and provides feedback to the prescribers. She continued that

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 _____	05/29/2019

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 881	Continued From page 33	F 881		

the pharmacy provides a monthly list of antibiotics that were dispensed for the previous month and the Unit Managers compare the list to the monthly surveillance logs that document: the resident, type of infection, if culture was done, and any follow-up such as antibiotics.

On 05/17/19 at 09:32 AM, an interview was conducted with the DON, who confirmed the information that was provided by the IP Coordinator.

On 05/17/19 at 3:35 PM, the surveyor spoke with the Administrator and the DON regarding the monitoring and tracking of infections. The Administrator stated that infection control was discussed in the quarterly quality assurance meetings. Both the DON and Administrator acknowledged that there were no antibiotic use protocols in place and that there was no system of collection of antibiotic use data and feedback.

NJAC 8:39-19.4 (d)