DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES				FOR	M APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	D. 0938-0391
	DF DEFIC ENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	· ,		STRUCTION	COMF	E SURVEY PLETED
		315280	B. WING				C / 13/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREE	TADDRESS, CITY, STATE, ZIP CODE	1 00	13/2021
				1417 B	RACE ROAD		
SILVER HI	EALTHCARE CENTER			CHER	RY 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 & CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F OC	00			
	REVISED						
		40, NJ144427, NJ141661, 6, NJ145690, NJ135912, 6, NJ145778,					
	Census: 147						
	Sample Size: 21						
	The facility is not in co requirements of 42 C Long Term Care Faci complaint survey.	FR Part 483, Subpart B, for					
	prevent resident-to-re (Residents #3, #14, # sampled residents for Resident #13 had a d and was NJ Exec. Ord #14, #15, #16, and #	 t15, #16, and #17) of 5 r resident-to-resident abuse. liagnosis of ^{NExec. Order 26:4.b.1} ler 26:4.b.1. Residents #3, 17 were assaulted by of the assaults resulted in 					
	with one or more requ caused, or was likely harm, impairment, or Immediate Jeopardy Operations Manual, <i>A</i> (Freedom from Abuse at a scope and sever	e facility's non-compliance uirements of participation to cause, serious injury, death to residents. The (IJ) was related to State Appendix PP, §483.12 e, Neglect and Exploitation) ity of "J." 9/2021 when the resident's					
		ne resident was no longer					
		SUPPLIER REPRESENTATIVE'S SIGNATUR	=		TITLE		(X6) DATE
	cally Signed	JULI LIEN NEFREJEN IATIVE S SIGNATURI	_		IIILE		08/27/2021
	carry orgined						JUILII 2021

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 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 13/2021
NAME OF P	ROVIDER OR SUPPLIER	L	I	ŝ	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 000	resident remained in assaulted another resident remained in assaulted another resident assaulted another resident assistant Director of I provided with the commotified of the existen Administrator signed the original to the sure On 08/11/2021 at 1:4 accepted by the New Health (NJDOH). The IJ continued until when the facility alleg Removal Plan had be On 08/13/2021 at 9:3 an onsite revisit to ve been implemented. Removed from the face facility implemented to included education for (CNAs), nursing assis nursing staff for the A Pavilion and Vent Unimonitor residents where being education for (cnAs), nursing assis nursing staff were being education for the face of a resident, n alone, ensuring that to by another staff mem	 A.b.1 resident ^{NJ Exec. Order 26:4.b.1} but the the facility. The resident sident on 08/08/2021. 00 PM, an IJ was identified. y Administrator and Nurses (ADON) were npleted IJ template and ce of an IJ for abuse. The the template and returned vey team. 1 PM, a Removal Plan was Jersey Department of 1 08/09/2021 at 10:00 PM, ted the elements of the ten implemented. 0 AM, a surveyor conducted rify the Removal Plan had tesident #13 had been illity on ^{NI Exec Order 26:4.b.1}. The he Removal Plan, which r certified nursing assistants stants (NAs), and licensed trium, Court Two, and its on how to properly 	F	0000			

Facility ID: NJ60407

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-					FORM	MAPPROVED 0. 0938-0391
	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:					PLETED
	315280	B. WING				C 1 3/2021
ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
EALTHCARE CENTER						
			C	CHERRY HILL, NJ 08034		
(EACH DEFIC ENC)	Y MUST BE PRECEDED BY FULL			· ·		(X5) COMPLETION DATE
Continued From page	2	F	000			
Pavilion Unit to includ one-to-one will have a and recreational activ another resident being behaviors. The facility current psychiatry gro The noncompliance re "no actual harm with t minimal harm that is r based on the following implemented all areas included the "at-risk" behaviors, care plans interventions, and the meetings with psychia (DON), Assistant Dire and Unit Managers (L and potential issues v medication changes of Safe/Clean/Comfortal CFR(s): 483.10(i)(1)-(§483.10(i) Safe Envir The resident has a rig comfortable and home but not limited to rece supports for daily livin The facility must prov §483.10(i)(1) A safe, of homelike environmen use his or her persona possible. (i) This includes ensu	e any resident on a seating plan during meals ities to lessen the chance of g harmed by impulsive will continue with the pup for continuity of care. emained on 08/13/2021 for the potential for more than not immediate jeopardy" g: The facility had not s of the Removal Plan that weekly meeting to discuss , and possibly new monthly psychotropic atrists, Director of Nursing ector of Nursing (ADON), JMs) to discuss any actual which may include or additional interventions. ble/Homelike Environment (7) onment. ght to a safe, clean, elike environment, including iving treatment and g safely. ide- clean, comfortable, and t, allowing the resident to al belongings to the extent ring that the resident can	F	584			8/30/21
	S FOR MEDICARE & I S FOR MEDICARE & I PEDEFIC ENCIES CORRECTION ROVIDER OR SUPPLIER EALTHCARE CENTER SUMMARY ST/ (EACH DEFIC ENCIENC REGULATORY OR I Continued From page The facility had an up Pavilion Unit to includ one-to-one will have a and recreational activ another resident being behaviors. The facility current psychiatry gro The noncompliance re "no actual harm with f minimal harm that is r based on the following implemented all areas included the "at-risk" behaviors, care plans interventions, and the meetings with psychia (DON), Assistant Dire and Unit Managers (U and potential issues v medication changes of Safe/Clean/Comfortal CFR(s): 483.10(i)(1)-(0 §483.10(i) Safe Envirn The resident has a rig comfortable and hom- but not limited to rece supports for daily livin The facility must prov §483.10(i)(1) A safe, for homelike environment use his or her persona- possible. (i) This includes ensu	CORRECTION IDENT FICATION NUMBER: 315280 ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION) Continued From page 2 The facility had an updated seating chart of the Pavilion Unit to include any resident on one-to-one will have a seating plan during meals and recreational activities to lessen the chance of another resident being harmed by impulsive behaviors. The facility will continue with the current psychiatry group for continuity of care. The noncompliance remained on 08/13/2021 for "no actual harm with the potential for more than minimal harm that is not immediate jeopardy" based on the following: The facility had not implemented all areas of the Removal Plan that included the "at-risk" weekly meeting to discuss behaviors, care plans, and possibly new interventions, and the monthly psychotropic meetings with psychiatrists, Director of Nursing (DON), Assistant Director of Nursing (ADON), and Unit Managers (UMs) to discuss any actual and potential issues which may include medication changes or additional interventions. Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent	S FOR MEDICARE & MEDICAID SERVICES OF DEFICENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER: (X2) MUL A BUILD 315280 B. WING ROVIDER OR SUPPLIER 315280 SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION) D PREFI TAG Continued From page 2 F The facility had an updated seating chart of the Pavilion Unit to include any resident on one-to-one will have a seating plan during meals and recreational activities to lessen the chance of another resident being harmed by impulsive behaviors. The facility will continue with the current psychiatry group for continuity of care. 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S FOR MEDICARE & MEDICAID SERVICES OF DEFIC ENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER. (X2) MULT PLIA A. BUILDING_ 315280 B. WING 315280 B. WING CORRECTION 315280 ROVIDER OR SUPPLIER D. WING SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY WUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION) P. P. PREFIX TAG Continued From page 2 F 0000 The facility had an updated seating chart of the Pavilion Unit to include any resident on one-to-one will have a seating plan during meals and recreational activities to lessen the chance of another resident being harmed by impulsive behaviors. The facility will continue with the current psychiatry group for continuity of care. 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F 584 (S483.10(i)(1) A safe, clean, comfortable, and homel	S FOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES (*1) PROVIDERSUPPLIERCULA IDENT FICATION NUMBER: (x2) MULT FLE CONSTRUCTION A BUILDING 315280 B. WING COMDER OR SUPPLIER STREET ADDRESS, GTY, STATE, ZIP CODE MALTHCARE CENTER STREET ADDRESS, GTY, STATE, ZIP CODE IMAL SUBMARY STATEMENT OF DEFIC ENCIES (EACH OFFIC SNCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION) D PREFIX TAG PREFIX (CACH CORRECTURATION SHOULDS) Continued From page 2 F 000 PREFIX TAG PROVIDER SPLAN OF CORRECTOR (EACH CORRECTURATION SHOULDS) Continued From page 2 F 000 PROVIDER SPLAN OF CORRECTURATION SHOULDS (COSS-REFERENCED TO THE APROPRING DEFICIENCY) Continued From page 2 F 000 F 000 PREFIX TAG PROVIDER SPLAN OF CORRECTURATION SHOULDS (COSS-REFERENCED TO THE APROPRING DEFICIENCY) Continued From page 2 F 000 F 000 PROVIDER SPLAN OF CORRECTURATION SHOULDS (COSS-REFERENCE) Continued From page 2 F 000 F 000 F 000 F 000 The noncompliance remained on 08/13/2021 for "no actual harm with the potential for more than minimal harm with the potential for more than minimal harm with the oscillation and the precemption peakage on the following: The facility had not inpermented all areas of the Removal Plan that included the "at-it-R'weeking to discuss behaviors, care plans, and possibly new interven	MENT OF HEALTH AND HUMAN SERVICES FOR MEDICARE & MEDICALD SERVICES OMB NC SFORM EDICARE & MEDICALD SERVICES OMB NC STORECTION (1) PROVIDER SUPPLER STREET ADDRESS, CITY, STATE, ZP CODE 1417 BRACE ROAD CHERRY HILL, NJ 08034 SUMMARY STATEMENT OF DEFIC ENCIES CONSTRUCTION REGULATORY OR LSC DENT FY NG INFORMATION) Continued From page 2 The facility Hidd an updated seating chart of the Pavilion Unit to include any resident on one-to-one will have a seating plan during meals and recreation activities to lessen the chance of another resident being harmed by impulsive behaviors. The facility will continue with the current psychiatry group for continuity of care. The noncompliance remained on 08/13/2021 for 'no actual harm with the potential for more than minimal harm that is not immediate jeopardy' based on the following: The facility and not implemented all areas of the Removal Plan that include the "artirsk" weekly meeting to discuss behaviors. The splank, and possibly new interventions, and the monthly psychotropic meetings with splaychiatry include and optential sease with chance and and potential sease with chances any actual and potential sease with environment. CFR(s): 483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike Environment. The resident has a right to a safe, clean, comfortable and homelike environment, and with life nesident to use his on the presonal belongings to the extent possible. () This includes ensuring that the resident to use his on the presonal belongings to the extent possible.

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		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 LETED		
		315280	B. WING				C 13/2021		
NAME OF P	ROVIDER OR SUPPLIER			S	TREET 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 584	physical layout of the independence and do (ii) The facility shall ei the protection of the r or theft. §483.10(i)(2) Housek services necessary to and comfortable inter §483.10(i)(3) Clean b in good condition; §483.10(i)(4) Private resident room, as spe §483.10(i)(5) Adequa levels in all areas; §483.10(i)(6) Comfort levels. Facilities initial 1990 must maintain a 81°F; and §483.10(i)(7) For the sound levels. This REQUIREMENT by: Complaint Intake NJ Based on observatior procedure review, it w facility failed to clean floors for 3 (Room 21	facility maximizes resident bes not pose a safety risk. xercise reasonable care for esident's property from loss eeping and maintenance o maintain a sanitary, orderly, ior; ed and bath linens that are closet space in each ecified in §483.90 (e)(2)(iv); te and comfortable lighting table and safe temperature ly certified after October 1, a temperature range of 71 to maintenance of comfortable	F	584	There were no specific residents effect by this deficient practice All residents are at risk for this alleged deficiency. We made sure every room was cleaned right away and had the Housekeeping Director inspect them to confirm. To ensure that this does not reoccur, th housekeeping director educated staff of proper rounding and clean up routines. To monitor the corrective action: The) ne on			

Event ID: IV9211

Facility ID: NJ60407

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					NISTRUCTION		<u>10. 0938-03</u>
	OF DEFIC ENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	· /		DNSTRUCTION		TE SURVEY MPLETED
			A. BUILDIN				С
		315280	B. WING	WING		0	8/13/2021
NAME OF P	ROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE		0/10/2021
_				1417	BRACE ROAD		
SILVER HI	EALTHCARE CENTER			CHE	RRY 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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 584	Continued From page	<u>م</u>	F 58	84			
		ourt Two Hallway A on	1.50	-	nousekeeping Director will continue	to	
		M, open doors to Room 212			audit at least 3x a week randomly x6		
		ion of debris on the floor			weeks.		
	which included bits of	f paper, a tissue, and dirt.		ר	To ensure all rooms are being prope	rly	
	•	m 214 revealed an opened			cleaned we will be reviewing these a	audits	
		on the floor under a raised			by the QA meetings for the next 2		
		ris of bits of paper and dirt.			quarters.		
		m 217 revealed many black			The Administrator and Housekeeping		
	floor space and other	debris over half the open			Director will be responsible for this p correction. Substantial compliance v		
	noor space and other	bits of paper debits.			achieved by 08/30/2021	viii be	
	On 08/06/2021 at 1:3	2 PM, an interview was					
		ekeeper #1 on Court Two					
	Hallway B. The house	ekeeper stated she had					
	-	an Hallway B for the last					
		e housekeeper stated she					
		A, and the housekeeper					
		A did not come to work #1 stated she did not know					
	who would clean Hall						
		4 AM, an interview was					
		ekeeper #3, who was					
	observed on Court Tw						
	housekeeper stated s	t Two and was supposed to					
	•	ndry. The housekeeper					
	-	told to come to the floor to					
		hallway since someone was					
		ousekeeper indicated she					
	was not really here to	clean all these rooms.					
	On 08/07/2021 at 1:2	7 PM, an observation from					
	Hallway A into open o	doors of resident rooms					
		still had bits of paper and					
		floor, Room 214 still had a					
		wrapper on the floor along					
		debris, and Room 217 still					
	had a large amount o	of rectangular black debris					

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		D HUMAN SERVICES MEDICAID SERVICES				FORM): 02/23/2023 APPROVED 0. 0938-0391
STATEMENT C	OF DEFIC ENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	. ,			(X3) DATE COMP	SURVEY LETED
		315280	B. WING		_		C 13/2021
NAME OF PF	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STA	ATE, ZIP CODE		
SILVER HI	EALTHCARE CENTER			417 BRACE ROAD HERRY HILL, NJ 08034	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	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE ICED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 584	made of the debris vis Licensed Practical Nu Manager (UM) #3. Th did not know the sche had not seen a house The LPN and UM did substance was on the stated they would hav to clean it. On 08/08/2021 at 8:1 [°] conducted with the Ac Administrator stated t about 15 rooms to cle cleaned daily. The ho in the building this we in the process of activ housekeepers. On 08/09/2021 at 10:° conducted with House housekeeper stated s Court Two Hallway A [°] housekeeper stated s weekend, and the roo had been cleaned, an On 08/09/2021 at 11:° conducted with the Ho The HD stated this we housekeeping staff ca resigned. The HD star assigned as a floater	he floor. 3 PM, an observation was sible in Room 217 with trse (LPN) #3 and Unit e LPN and UM stated they edule of housekeepers and keeper on the unit this day. not know what the e floor of Room 217 but re a housekeeper come up 7 AM, an interview was dministrator. The hat each housekeeper had an, and the rooms were usekeeper director was not ekend. The facility was still rely looking to hire more 33 AM, an interview was ekeeper #5. The he was scheduled to clean for the past two months. The he was off this past ms did not appear as if they d the floors were very dirty. 44 AM, an interview was busekeeping Director (HD). ekend he had all out and one staff ted Housekeeper #3 was to clean Court Two halls	F 584		(EFICIENCY)		
	assigned as a floater when the regular staff						

Facility ID: NJ60407

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ATEMENT	OF DEFIC ENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT F	LE CONSTRUCTION	(X3) DATE S	SURVEY		
	CORRECTION	IDENT FICATION NUMBER:	. ,	B	COMPL			
						;		
		315280	B. WING		08/1	3/2021		
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
SILVER HI	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 PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE		
F 584	Continued From page	9 6	F 58	34				
		v procedure, titled, Cleaning						
	Methods-Housekeepi	ng, updated on 05/17/2021,						
	included under Stand rooms will be perform	ard: Cleaning of residents' led daily.						
	New Jersev Administ	rative Code § 8:39-31.4(a)						
F 600	-	- , ,	F 60	00		8/30/21		
SS=J	CFR(s): 483.12(a)(1)							
	-	m Abuse, Neglect, and						
	Exploitation The resident has the	right to be free from abuse,						
		tion of resident property,						
		efined in this subpart. This						
	includes but is not lim	inted to freedom from						
		ical restraint not required to						
	treat the resident's m							
	§483.12(a) The facilit	y must-						
	§483.12(a)(1) Not use	e verbal, mental, sexual, or						
	physical abuse, corpo							
	involuntary seclusion							
	This REQUIREMENT	is not met as evidenced						
	Complaint Intake NJ	145778		Resident #13 is no longer in the	facility.			
				Residents #3, #14, #15, #16, and				
	Based on observation	ns, record reviews, y policy review, it was		remain residents in the facility an had no further incident. There we				
	-	y failed to provide a safe		other residents affected by this d				
	environment to preve	nt resident-to-resident		practice				
		ts #3, #14, #15, #16, and		All residents are at risk for this al	leged			
	#17) of 5 sampled resident a	sidents for buse. Resident #13 had a		deficiency To ensure that this does not reod	cur an			
	diagnosis of NJ Exec. Order	^{26:4.b.1} and was ^{NJ Exec. Order 26 4.b.1}		education was initiated for all nur				
		s #3, #14, #15, #16, and #17		including agency, on 8/8/2021 or				
		esident #13. Some of the		properly perform one to one safe				

Event ID: IV9211

Facility ID: NJ60407

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TATEMENT	OF DEFIC ENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT F	PLE CONSTRUCTION	OMB NO. (X3) DATE SU	JRVEY
ND PLAN OF	CORRECTION	IDENT FICATION NUMBER:	A. BUILDING	G	COMPLE	TED
		315280	B. WING			8/2021
NAME OF P	ROVIDER OR SUPPLIER	•	•	STREET ADDRESS, CITY, STATE, ZI	P 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 LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETIO DATE
F 600	It was determined the with one or more req caused, or was likely harm, impairment, or Immediate Jeopardy Operations Manual, <i>A</i> (Freedom from Abuse at a scope and sever The IJ began on 07/2 physician indicated th other residents. The resident remained in assaulted another res On 08/08/2021 at 12: At 5:16 PM, the facilit Assistant Director of provided with the corn notified of the exister Administrator signed the original to the sur On 08/11/2021 at 1:4 accepted by the New Health (NJDOH).	U Exec. Order 26:4.b.1 a facility's non-compliance uirements of participation to cause, serious injury, death to residents. The (IJ) was related to State Appendix PP, §483.12 e, Neglect and Exploitation) ity of "J." 29/2021 when the resident's he resident was were order 264.b1 with resident needed were order 264.b1 but the the facility. The resident sident on 08/08/2021. 00 PM, an IJ was identified. ty Administrator and Nurses (ADON) were npleted IJ template and nee of an IJ for abuse. The the template and returned	F 60		nd was by ADON, DON, y staff will check omplete ber one to one ing their shift tisk" meeting was sidents at risk for 08/13/2021 and y basis. Monthly as planned on 26/21 to review changes, havior as behaviors. The seting will be asis. Any new fied will be nerventions as Kardex will be eaction: A ne performance ented on 8/9/2021 hly 2 times per cility will perform dents if one to asary. Unit ignee will perform one audits, "at hly psychotropic d at the facility	
		ged the elements of the		Nursing/designee will be this plan of correction an be achieved by 08/30/20	responsible for d compliance will	
	On 08/13/2021 at 9:3	0 AM, a surveyor conducted				

Facility ID: NJ60407

If continuation sheet Page 8 of 36

	MENT OF HEALTH AN S FOR MEDICARE & I						FORM): 02/23/2023 MAPPROVED). 0938-0391
STATEMENT	DF DEFIC ENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	· <i>`</i>		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		315280	B. WING					C 13/2021
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, Z	IP 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 (EACH CORRECTIVE / CROSS-REFERENCED DEFICI	ACTION SHOULD BI		(X5) COMPLETION DATE
F 600	been implemented. R removed from the fact facility implemented th included education fo (CNAs), nursing assiss nursing staff for the A Pavilion and Vent Unit monitor residents who behavior monitoring. C staff were being educ reach of a resident, no alone, ensuring that th by another staff memil and documenting who The facility had an up Pavilion Unit to includ one-to-one will have a and recreational active another resident being behaviors. The facility current psychiatry gro The noncompliance re "no actual harm with the minimal harm that is r based on the following implemented all areas included the "at-risk" of behaviors, care plans interventions, and the meetings with psychia (DON), Assistant Dire and Unit Managers (L and potential issues of	rify the Removal Plan had esident #13 had been ility on ^{N Exec Order 26 4b1} . The he Removal Plan, which r certified nursing assistants stants (NAs), and licensed trium, Court Two, and ts on how to properly o were on one-to-one CNAs, NAs, and licensed ated on staying within arm's ever leaving a resident he one-to-one was covered ber when going to break, ereabouts and behaviors. dated seating chart of the e any resident on a seating plan during meals ities to lessen the chance of g harmed by impulsive v will continue with the up for continuity of care. emained on 08/13/2021 for he potential for more than not immediate jeopardy" g: The facility had not s of the Removal Plan that weekly meeting to discuss , and possibly new monthly psychotropic atrists, Director of Nursing ictor of Nursing (ADON), JMs) to discuss any actual	F	600				

Facility ID: NJ60407

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	OF DEFIC ENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:				(X3) DATE COMF	SURVEY PLETED
		315280	B. WING				C 13/2021
NAME OF P	ROVIDER OR SUPPLIER	L		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00	
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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 600	Continued From page	9	F	600			
	to the New Jersey De (NJDOH) on 05/31/20 Resident #3 was the assault by Resident # Resident #3 being NJ Resident #13 had dia NJ Exec. Order 26:4 admission Minimum E 04/05/2021, indicated	21 revealed the following: victim of an unproved 13. The attack resulted in Exec. Order 26:4.b.1 gnoses which included					
		26:4.b.1 . The resident h.b.1 e resident had ^{NJ Exec. Order 26:4.b.1} observed Resident #13					
	reported by an eyewit indicated Resident #1 resident (Resident #1 waiting for dinner in th #15's statement revea Resident #15 in the fa Resident #15 had dia	eport dated 04/22/2021, tness (another resident), 13 had slapped a female 5) across the face, while ne activity room. Resident aled Resident #13 smacked ace. gnoses which included identNJ Exec. Order 26:4.b.1					

Facility ID: NJ60407

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFIC ENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	
		315280	B. WING				
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	(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 600	NJ Exec. Order 26:4 The report indicated F allegation at first then resident stated Resid Resident #13's food s Resident #15. There report did not state wi received injuries. The resident's care pli indicated the resident interventions put in pl NJ Exec. Order 26:4 get upset. The resident's care pli #13 NJ Exec. Order 26:4 Mo new order NJ Exec. Order 26:4 NJ Exec. Order 26:4 No one-on-one monit provided by the facilit	A.b.1 . Resident #13 denied the changed the story. The ent #15 had touched so Resident #13 smacked were no staff witnesses. The hether Resident #15 Ian dated 04/22/2021 could NJ Exec. Order 26:4.b.1 The ace were: A.b.1 Ian also indicated Resident 26:4.b.1 S note dated 04/23/2021 s: 1. Resident #13 was to be 4.b.1 .b.1 oring documentation was	F	600			

Facility ID: NJ60407

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	OF DEFIC ENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		315280	B. WING				C 13/2021
NAME OF P	ROVIDER OR SUPPLIER		•		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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 600	4:30 PM revealed bot dining room when Re in the face. Resident # hitting Resident #13 in Resident #16 had a d was NJ Exec. Order It was noted Resident were separated, but is Resident #13 tried to Resident #13 tried to Resident #13 Both re "Sec Order", and 911 was a #13 to a local crisis ca indicated the resident (no time given). The resident's care pl revealed additional in 1. NJ Exec. Order 26 The resident's care pl #13 NJ Exec. Order 26 The resident's care pl #13 NJ Exec. Order 26 The resident's care pl #13 NJ Exec. Order 26 The only new interver resident on NJ Exec. Order	th residents were in the sident #13 hit Resident #16 #16 retaliated and started in the face. liagnosis of ^{IN Exec. Order 26:4.b.1} and 26:4.b.1 t #13 had ^{NJ Exec. Order 26:4.b.1} he residents ater in the same mealtime, hit Resident #16 again. throwing punches at esidents were ^{IN Exec Order 26:4.b.1} called to transfer Resident enter. The incident report twas ^{NJ Exec. Order 26:4.b.1} lan updated on 04/28/2021 terventions: 5:4.b.1	F	600			

Facility ID: NJ60407

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	D: 02/23/2023 MAPPROVED D. 0938-0391
STATEMENT (DF DEFIC ENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	ì, í		LE CONSTRUCTION		(X3) DATE COMF	SURVEY PLETED
		315280	B. WING			– C – 08/13/2021		
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
	EALTHCARE CENTER				1417 BRACE ROAD			
OILVEIN					CHERRY HILL, NJ 0803	34		
(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	IX	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	Resident #13 would b when returned to the facility after inquiries. Per the care plan, ^{NEEE} intervention, and no ti related to how long ^{NEE} provided. The inciden Resident #13 was stil a physician order date A physician's order date Resident #13 was to checks for ^{NEEC Order 264bl} . 3. A facility incident re 2:42 PM indicated arc went to the activity ro- to escort the resident NI Exec. Order 26:4.b.1. The behind as she left to r the resident's room. F unattended as Reside #13 in the hallway. Th turned around and sa Resident #3 in the fac unprovoked. The incide residents were separa NJ Exec. Order 26:4.	her interventions had hended. r Resident #16 revealed be NJ Exec. Order 26:4.b.1 facility. No ^{NJ Exec. Order 26:4.b.1} was provided by the c Order 26:4.b.1 was not a new ime frame was provided ec. Order 26:4.b.1 would be t report did not indicate if I on NJ Exec. Order 26:4.b.1 per ed 04/23/2021. ated 04/30/2021 indicated be placed NJ Exec. Order 26:4.b.1 eport dated 05/31/2021 at bound 10:00 AM, a nurse om to retrieve Resident #13 to the resident's room for a nurse left Resident #13 nove the treatment cart to Resident #13 was walking ent #3 walked by Resident he nurse heard a sound, w that Resident #13 had hit ize. The attack was dent report indicated the ated and Resident #3 was	F	60		DEFICIENCY)		
		to be transported to the						

Facility ID: NJ60407

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT (DF DEFIC ENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:				(X3) DATE COM	E SURVEY PLETED
		315280	B. WING				C / 13/2021
NAME OF P	ROVIDER OR SUPPLIER	I			STREET ADDRESS, CITY, STATE, ZIP CODE	1	
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 PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 600	crisis center. NJ Exec. initiated, per physicia NJ Exec. Order 26:4.b.1	. Order 26:4.b.1 was n order, until evaluated by	F	600	0		
	No psychiatric consult note was provided by the facility after inquiries. No NI Exec. Order 26 4.6.1 monitoring documentation was provided by the facility after inquiries.						
	A nurse's note dated 05/31/2021 at 8:28 PM indicated Resident #3 returned to the facility with NJ Exec. Order 26:4.b.1						
	Resident #13's care p intervention was to pl NJ Exec. Order 26:4	ace Resident #13 on					
	This intervention was	not new.					
	indicated Resident #1	rs note dated 05/31/2021 13 was to be placed on red by <mark>NJ Exec. Order 26:4.b.1</mark>					
	The care plan contair	ned no new interventions.					
	(DON) on 07/07/2021 Resident #13 was to checks for NJ Exec. (by the Director of Nurses at 3:00 PM indicated be placed on ^{N Exec. Order 26 4.b.1} Order 26:4.b.1 documented every shift.					
	4:30 PM reported Re Resident #14 when R Resident #14. The st	eport dated 07/13/2021 at sident #13 was walking past Resident #13 started hitting aff separated the residents, tinued to threaten the other					

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT	DF DEFIC ENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		315280	B. WING				C / 13/2021
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
SII VER 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 600	resident. Both resider crisis center. Neither they were both placed returned to the facility Resident #14 had NJ No one-on-one monite provided by the facility Resident #14 had a d Resident #13's care p interventions. A physician's order da indicated Resident #1 reports were in the me the resident had beer A physician's order da Resident #13 was to to NJ Exec. Order 26 residents. The residen resident was NJ Exect The above handwritte large circle drawn aro star and a big check r On 08/07/2021 at 9:4 observed by the surve	hts were sent out to a local resident had ^{Were order 20} and d on ^{NEecc Order 26 4.b.1} when they 7. The report indicated Exec. Order 26 4.b.1 oring documentation was y after inquiries. liagnosis of ^{NJ Exec. Order 26 4.b.1} olan contained no new ated 07/15/2021 (no time) 13 was ^{NJ Exec. Order 26 4.b.1} No edical record that indicated in sent to the crisis center. ated 07/29/2021 indicated be kept on ^{NEEcc. Order 26 4.b.1} due 5 4.b.1 with other int needed ^{NECC. Order 26 4.b.1} The c. Order 26 4.b.1	F	600			

Facility ID: NJ60407

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 02/23/2023 MAPPROVED). 0938-0391
STATEMENT (DF DEFIC ENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE A. BUILDING		(X3) DATE SURVEY COMPLETED		
		315280	B. WING	-		C 13/2021	
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STA	ATE, ZIP CODE		
SILVER H	EALTHCARE CENTER			417 BRACE ROAD HERRY HILL, NJ 08034	l I		
(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 CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 600	room with the resident On 08/07/2021 at 12: observed by the surve near the dining/activit supervision. It was ob member providing On 08/08/2021 at 10: was asked why Resid immediately transferre the physician wrote a NJ Exec. Order 26:4 spoke with him on 07 express to him the resi NJ Exec. Order 26:4 stated he contacted a day (07/30/2021) and NJ Exec. Order 26:4 the following week (00 refused to allow the re- stated the resident ha made it more difficult resident. The Administrator sta additional arrangeme out of the unit. The Ad- the resident was not to behavior unit. He state physician in charge of the resident. He adde had said the resident he would not accept for stated he did not rem	seated in the dining/activities it. 11 PM, Resident #13 was eyor walking in the hallway ies room without bserved there was no staff corder 26 4.5.1 00 AM, the Administrator lent #13 was not ed to another facility when n order (on 07/29/2021) to 4.5.1 He stated the physician /29/2021 and did not sident needed to be 1.5.1 . The Administrator is sister facility the following arranged for the resident to	F 600				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 02/23/2023 MAPPROVED). 0938-0391
STATEMENT	DF DEFIC ENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	· · /			(X3) DATE COMP	SURVEY LETED
		315280	B. WING		_		C 13/2021
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	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BINCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	facility is required to the facility is required to the The Administrator was documentation of atter for the resident. He state for the resident. He state there was no docume A facility incident report 11:10 AM revealed Resident #17 on the repisode occurred in the Resident #17 on the repisode occurred in the Resident #13 was obstated to NJ Exern Resident #17 in the fattransferred to NJ Exern Resident #17 hospital for evaluation incident report revealed (CNA) #6 (who was a NU Exec Order 26 4.5.1) provided indicated she was not Resident #13 started face. Resident #17 was NJ On 08/08/2021 at 11:3 stated CNA #6 had be NU Exec Order 26 4.5.1 for Resident During the survey, muto reach CNA #6. On more attempts were remultiple attempts had	xec. Order 26:4.b.1 Then t back to the facility, and the ake the resident back. s asked to provide empts to provide placement ated everything was verbal. entation of anything. ort dated 08/08/2021 at esident #13 repeatedly hit ight side of the face. This he activities/dining room. served to stand up, 17 and start punching ace. Resident #13 was c. Order 26:4.b.1 7 was transferred to a local h and treatment. The ed Certified Nurse Aide ssigned to provide a written statement which t with Resident #13 when hitting Resident #17 in the Exec. Order 26:4.b.1 30 AM, Unit Manager #3 een assigned to provide	F 600				

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	2: 02/23/2023 APPROVED 0: 0938-0391
STATEMENT (DF DEFIC ENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		315280	B. WING		_) 180	; 13/2021
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET 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 SC IDENT FY NG INFORMATION)	D PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	Continued From page on.	17	F 600				
	returned from the hos sitting in the dining/ac	5 PM, Resident #17 had pital and was observed stivity room. The ^{N Exec. Order 264.6.1}					
	#1, #7, and #8) who p Resident #13 stated t unpredictable. There would set the residen too close, the residen other resident. If a res resident would strike resident. Resident #1 residents to be near. just did not like the wa	was no way to predict what t off. If another resident got t would jump up and hit the sident walked by, the					
	physician was contac	20 AM, Resident #13's ted by phone. He stated he lidn't have the medical ne didn't remember					
	the DON (Director of physician's order did needed to be immedia physician had spoken did not tell them to tra immediately. They we documentation of NJ E Resident #13, such as they did not have a for	n with each of them, and he Insfer the resident ere asked if there was xec. Order 26:4.b.1 for s ^{N Exec. Order 26:4.b.1} . They stated					

Facility ID: NJ60407

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	-					FORM	02/23/2023
STATEMENT (S FOR MEDICARE & I OF DEFIC ENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	LETED
		315280	B. WING		_	(08/	C 13/2021
NAME OF PI	ROVIDER OR SUPPLIER		s	STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
			1	417 BRACE ROAD			
SILVER H	EALTHCARE CENTER		C	CHERRY HILL, NJ 0803	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) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	been reviewed, and if put in place after ever the resident was alwa On 08/20/2021 at 2:11 physician stated he ha #13 be NJ Exec. Ord The physician added crisis center multiple to effective. The facility I assaults on other resi resident on one on or had discussed medica resident and a family refused, because they need medications. The everything had failed transferred out as qui immediately if possibl The physician stated placement in the facilit He stated he was told issue, and the resider The physician stated Administrator, DON, a stated he verbalized t transferred quickly, be Me stated his j recommendations, it w decide how to handle The facility's abuse po- indicated: "POLICY	re asked if interventions had been ry altercation. They stated bys on ^{NExec Order 26 4.b.1} . 5 PM, the resident's ad recommended Resident er 26:4.b.1 the resident had been to a times and that was not had been unable to prevent dents by placing the ne. The physician stated he ation changes with the member, and they had y felt the resident did not he physician stated since the resident needed to be ckly as possible, e. he had inquired about ity behavior unit downstairs. I there were insurance nt did not qualify. he did speak with the and the social worker. He he resident needed to be ckly as possible, e.	F 600				

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT (DF DEFIC ENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		315280	B. WING				C / 13/2021
NAME OF PI	ROVIDER OR SUPPLIER			:	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 PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 600	right to be free from a misappropriation of re punishment, and invo accordance with State 2. Silver Healthcare C form of resident abuse monitor our facility's p programs, systems, e resident abuse. 3. All alleged or suspe neglect, mistreatment residents' property wi and findings documer 4. Any case in which a mistreatment, or misa property has been sus accordance with State DEFINITIONS ABUSE: The infliction of injury intimidation or punish harm, pain or mental the deprivation by an caretaker, of goods of necessary to attain or or psychological well- instances of abuse of a coma, cause physic anguish" There was no facility monitoring. On 08/11/2021 at 1:4' received and accepte Removal Plan:	buse, neglect, esident property, corporal luntary seclusion in e and Federal regulations. Center will not condone any e and will continually policies, procedures, training tc., to assist in preventing ected incidents of abuse, c, or misappropriation of II be thoroughly investigated, need in a report format. abuse, neglect, uppropriation of residents' spected will be reported in e and Federal regulations. , unreasonable confinement, ment with resulting physical anguish. This also includes individual, including a r services that are maintain physical, mental, being. This presumes that all residents, even those in cal harm or pain or mental policy on one-to-one	F	600			

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	MENT OF HEALTH AN						FORM): 02/23/2023 MAPPROVED). 0938-0391
STATEMENT	OF DEFIC ENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	` <i>'</i>		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		315280	B. WING					C 13/2021
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STAT	TE, 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 PREF TAG		(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD B CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 600	8/09/21 by 10:00pm. Resident #13 was ser for NJ Exec. Order 2 Resident #13 will not Healthcare Center. The facility currently h one observation beca poor safety awarenes Residents at risk for s behavior will be audite be updated if appropr The facility started ed licensed nursing staff Pavilion and vent unit residents who are on monitoring. CNAs, N being educated on sta the resident, never lea ensuring that the one another staff member document whereabout education was initiate completed by 8/9/202 Behaviors will be disc new interventions initi meetings. The attend the Medical Director, ADON, Dietician, and Clinical Interdisciplina "at risk" meetings will kardex via point click	ng since ^{N inc. order2} . The harm no longer exists as of to emergency department 6:4.b.1 . be returning to Silver has one resident on one to use he is a fall risk and has s. afety compromising ed and their care plans will iate on 8/09/21 by 10:00PM. ucation for CNAs, NAs, and for the Atrium, Court two, on how to properly monitor one to one behavior As, and license staff are aying within arm's reach of aving a resident alone, to one is covered by when going to break, and its and behaviors. This d on 8/8/21 and will be 1 by 10:00 PM. cussed, care planned, and fated weekly during "at risk" lees of these meeting are social workers, DON, IP,	F	600				

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	-	ID HUMAN SERVICES				FORM	APPROVED
	S FOR MEDICARE & I	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	T PI	LE CONSTRUCTION	(X3) DATE	0. 0938-0391
	CORRECTION	IDENT FICATION NUMBER:					LETED
							0
		315280	B. WING			08/	13/2021
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE 1417 BRACE ROAD		
SILVER H	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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 600	Continued From page floor nurses, NAs, and will also take place ver- written as orders or in Monthly psychotropic DON, ADON, and Un actual and potential is medication changes of Any resident displayin behaviors that may be have an arranged sea recreational activities another resident being behaviors. We will co- psychiatry group for of Admissions will comm DON, ADON and Uni- whether the facility ca- with behaviors. Residents with history deemed a danger to of who are no longer ap- will be sent to crisis for immediately. If the ps- resident is a danger to not be accepting the r On 08/13/2021 at 9:37 an onsite revisit to ver- been implemented. R	e 21 d CNAs. Communication erbally and may even be n-services when appropriate. meetings with psychiatrists, it Managers to discuss any ssues which may include or additional interventions. In gaggressive or other e detrimental to others will ating plan during meals and to lessen the chance of g harmed by impulsive ontinue with the current continuity of care. Inunicate with Administrator, t Managers to determine an properly care for residents of aggression who are other residents and staff, propriate for SNF placement or further evaluation ychiatrist still feels that the o others, then the facility will		600	DEFICIENCY)		
	facility implemented the included education fo	he Removal Plan, which r certified nursing assistants stants (NAs), and licensed					

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	-	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		SURVEY PLETED		
		315280	B. WING			08/13/202			
NAME OF PF	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	-			
SILVER HI	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	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE		
F 689	staff were being educ reach of a resident, n alone, ensuring that t by another staff mem and documenting whe The facility had an up Pavilion Unit to includ one-to-one will have a and recreational activ another resident bein behaviors. The facility current psychiatry gro The noncompliance re "no actual harm with t minimal harm that is r based on the followin implemented all areas included the "at-risk" behaviors, care plans interventions, and the meetings with psychia (DON), Assistant Dire and Unit Managers (U and potential issues v medication changes of New Jersey Administr	trium, Court Two, and ts on how to properly o were on one-to-one CNAs, NAs, and licensed ated on staying within arm's ever leaving a resident he one-to-one was covered ber when going to break, ereabouts and behaviors. dated seating chart of the le any resident on a seating plan during meals ities to lessen the chance of g harmed by impulsive v will continue with the oup for continuity of care. emained on 08/13/2021 for the potential for more than not immediate jeopardy" g: The facility had not s of the Removal Plan that weekly meeting to discuss a, and possibly new e monthly psychotropic atrists, Director of Nursing ector of Nursing (ADON), JMs) to discuss any actual which may include or additional interventions.		689			8/30/21		
SS=H	CFR(s): 483.25(d)(1) §483.25(d) Accidents The facility must ensu								

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	-	D HUMAN SERVICES MEDICAID SERVICES			FOR	D: 02/23/2023 M APPROVED D. 0938-0391
STATEMENT (DF DEFIC ENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		315280	B. WING		C 08/13/2021	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
				1417 BRACE ROAD		
SILVER H	EALTHCARE CENTER			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 PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 689	as free of accident ha §483.25(d)(2)Each re supervision and assis accidents. This REQUIREMENT by: Complaint Intake: NJ Based on observation interviews, it was dete provide supervision to resident-to-resident a 15, 16, 17, and #19) of were reviewed for res This had the potential resided in the facility. Findings included: A review of a Facility to the New Jersey De (NJDOH) on 05/31/20 Resident #3 was the assault by Resident # Resident #13 had dia NJ Exec. Order 26:4	sident environment remains zards as is possible; and sident receives adequate tance devices to prevent is not met as evidenced 145778 is, record review, and ermined the facility failed to o prevent tercations for 5 (#3, #14, of 5 residents whose records ident-to-resident abuse. to affect all residents who Reported Event (FRE) sent partment of Health 21 revealed the following: <i>v</i> ictim of an unproved 13. The attack resulted in Order 26:4.b.1	F 68		nd #19 nd re is on 1:1 other e r, an ng staff ow to and ur /2021 ency to er one their audits	
	was NJ Exec. Order	he resident 26:4.b.1 ,		the facility QA meetings for the nex quarters.		

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 02/23/2023 MAPPROVED D. 0938-0391
STATEMENT (OF DEFIC ENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		315280	B. WING _				C 13/2021
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>		ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
SILVER H	EALTHCARE CENTER				117 BRACE ROAD 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	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 689	NJ Exec. Order 26:4 required NJ Exec. Or The MDS revealed the On 08/06/2021 it was resided NJ Exec. Or 1. A facility incident re reported by an eyewit indicated Resident #1 resident (Resident #1 waiting for dinner in the #15's statement revea Resident #15 in the fa Resident #15 had dia NEECOMPTICE and the res The report indicated F allegation at first them resident stated Resid Resident #13's food s Resident #15. There report did not state w received injuries. The resident's care p	4.b.1 . The resident rder 26:4.b.1 e resident had ^{NU Exec. Order 26 4.b.1} e observed Resident #13 der 26:4.b.1 eport dated 04/22/2021, tness (another resident), 13 had slapped a female 15) across the face, while he activity room. Resident aled Resident #13 smacked ace. egnoses which included ident NJ Exec. Order 26:4.b.1 Resident #13 denied the in changed the story. The lent #15 had touched so Resident #13 smacked were no staff witnesses. The hether Resident #15 lan dated 04/22/2021 t could become aggressive r residents. The lace were:	F	589	The Administrator and Director of Nursing/designee will be responsible for this plan of correction substantial compliance by 08/30/2021.	TC	

Event ID: IV9211

Facility ID: NJ60407

If continuation sheet Page 25 of 36

	-	ID HUMAN SERVICES				FORM	M APPROVED
STATEMENT	OF DEFIC ENCIES	(X1) PROVIDER/SUPPLIER/CLIA	· /		E CONSTRUCTION	(X3) DATE	
AND PLAN OF	CORRECTION	IDENT FICATION NUMBER:	A. BUILD	ING _		COMPLETE	
		315280	B. WING				C 13/2021
NAME OF P	ROVIDER OR SUPPLIER	l		5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
SILVER H	EALTHCARE CENTER				1417 BRACE ROAD		
							0(5)
(X4) ID PREFIX TAG	(EACH DEFIC ENC	ATEMENT OF DEFIC ENCIES Y MUST BE PRECEDED BY FULL LSC IDENT FY NG INFORMATION)	D PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 689	Continued From page NJ Exec. Order 26:4		F	689			
	The resident's care p #13 NJ Exec. Order	lan also indicated Resident 26:4.b.1					
	4:30 PM revealed bot dining room when Re	eport dated 04/28/2021 at th residents were in the sident #13 hit Resident #16 #16 retaliated and started n the face.					
	Resident #16 had a d was <mark>NJ Exec. Order</mark>	liagnosis of $26:4.b.1$ and $26:4.b.1$					
	were separated, but I Resident #13 tried to Resident #16 started Resident #13. Both re New Order, and 911 was #13 to a local crisis co indicated the resident center but returned to (no time given).	esidents were placed on called to transfer Resident enter. The incident report t was held at the crisis o the facility later in the night					
	The resident's care p revealed additional in	lan updated on 04/28/2021 terventions:					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT O	DF DEFIC ENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	
		315280	B. WING				/13/2021
NAME OF PI	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
SILVER HI	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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 689	 #13 initiated acts of p 04/28/2021. The only new interver resident on NJ Exec. Or not report a time fram be conducted. The ot already been recomm The incident report fo Resident #13 would be when returned to the One-on-one was not a time frame was provid one-on-one would be report did not indicate NJ Exec. Order 26:4.b.1 pr 04/23/2021. A physician's order da Resident #13 was to checks for NEEC Order 26:4b.1. 3. A facility incident re 2:42 PM indicated arc 	5:4.b.1 an also indicated Resident hysical aggression on ntion was to place the der 26:4.b.1. The report did the for NJ Exec. Order 26:4.b.1 to her interventions had hended. r Resident #16 revealed be placed ^{NJ Exec. Order 26:4.b.1} facility. a new intervention, and no ded related to how long provided. The incident a fResident #13 was still on the a physician order dated ated 04/30/2021 indicated be placed on ^{NJ Exec. Order 26:4.b.1} ated 04/30/2021 indicated be placed on ^{NJ Exec. Order 26:4.b.1} ated 04/30/2021 indicated be placed on ^{NJ Exec. Order 26:4.b.1}	F	689			
	went to the activity ro	ound 10:00 AM, a nurse om to retrieve Resident #13 to the resident's room for					

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	-	ID HUMAN SERVICES				FORM	M APPROVED
		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	T PI	E CONSTRUCTION		0. 0938-0391
STATEMENT OF DEFIC ENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENT FICATION NUMBER:		· /			(X3) DATE SURVEY COMPLETED		
				-			С
		315280	B. WING			08/	13/2021
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
SILVER H	EALTHCARE CENTER				1417 BRACE ROAD		
	1				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 689	behind as she left to r the resident's room. F unattended as Reside #13 in the hallway. Th turned around and sa Resident #3 in the fac unprovoked. The incid residents were separa NJ Exec. Order 26:4 Resident #3 was retur 2:00 PM. Resident #13 refused crisis center. One-on- initiated, per physician psychiatric consult. A nurse's note dated to indicated Resident #3 NJ Exec. Order 26:4 Resident #13's care p intervention was to pla NU Exec. Order 26:4 Resident #13's care p intervention was to pla NU Exec Order 26:4.5 This intervention was A physician's progress indicated Resident #1 NU Exec Order 26:4.5 The care plan contain A nurse's note written	e nurse left Resident #13 move the treatment cart to Resident #13 was walking ent #3 walked by Resident he nurse heard a sound, w that Resident #13 had hit ce. The attack was dent report indicated the ated and Resident #3 was Lb.1 	F	689			

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 02/23/2023 MAPPROVED). 0938-0391
STATEMENT (OF DEFIC ENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	` ´		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		315280	B. WING					C 13/2021
NAME OF P	ROVIDER OR SUPPLIER		I	S	TREET ADDRESS, CITY, STAT	E, ZIP CODE		
SILVER H	EALTHCARE CENTER			1,	417 BRACE ROAD			
				C	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 PREFI TAG		(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TVE ACTION SHOULD BI CED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
F 689	Continued From page Resident #13 was to checks for 72 hours fo were to be 4. A facility incident re 4:30 PM reported Res Resident #14 when R Resident #14. The sta but Resident #13 con resident. Both resider crisis center. Neither they were both placed returned to the facility Resident #14 had NJ Resident #14 had a d and was NJ Exec. Or Resident #13's care p interventions. A physician's order da indicated Resident #1 A physician's order da Resident #13 was to to NJ Exec. Order 20	e 28 be placed on ^{NI Exec. Order 26 4.b.1} or NJ Exec. Order 26:4.b.1 documented every shift. eport dated 07/13/2021 at sident #13 was walking past Resident #13 started hitting aff separated the residents, itinued to threaten the other ints were sent out to a local resident had ^{NI Exec. Order 26} and d on ^{NI Exec. Order 26:4.b.1} e when they <i>X</i> . The report indicated Exec. Order 26:4.b.1 diagnosis of ^{NJ Exec. Order 26:4.b.1} rder 26:4.b.1 olan contained no new ated 07/15/2021 (no time) 13 was ^{NJ Exec. Order 26:4.b.1} e due d 07/29/2021 indicated be kept on ^{NI Exec. Order 26:4.b.1}		689				
	skilled nursing facility should work with the The above handwritte	he c. Order 26:4.b.1 at this (SNF). A social worker						

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		ID HUMAN SERVICES				FORM	APPROVED 0. 0938-0391	
		(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		315280	B. WING				C 13/2021	
NAME OF PI	ROVIDER OR SUPPLIER	L		S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
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 PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				(X5) COMPLETION DATE	
F 689	star and a big check i On 08/07/2021 at 9:4 observed to be seated dining/activities room seated in the dining/a resident. On 08/07/2021 at 12: observed walking in t dining/activities room observed there was r one-on-one. On 08/08/2021 at 10: was asked why Resid immediately transferre the physician wrote a NJ Exec. Order 26:4 spoke with him on 07 express to him the re transferred out immediated he contacted at day (07/30/2021) and be transferred to [nam the following week (0) refused to allow the re stated the resident hat made it more difficult resident. The Administrator stat additional arrangeme out of the unit. The Administrator stat additional arrangeme	mark drawn beside it. 5 AM, Resident #13 was d without one-on-one in the . There were other residents activities room with the 11 PM, Resident #13 was he hallway near the without supervision. It was to staff member providing 00 AM, the Administrator lent #13 was not ed to another facility when n order (on 07/29/2021) to I.b.1 He stated the physician /29/2021 and did not	F	689				
	behavior unit. He stat	ransferred to the facility's ed he had tried but the f the unit would not accept						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT	DF DEFIC ENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	
		315280	B. WING				0 13/2021
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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)		(X5) COMPLETION DATE
F 689	the resident. He adde had said the resident he would not accept h stated he did not rem the physician at the b the resident was sent center only kept the re- they send the resident facility is required to t The Administrator wa documentation of atter for the resident. He st There was no docum A facility incident repor 11:10 AM revealed Re- Resident #17 on the r episode occurred in tt Resident #13 was ob- approach Resident #7 Resident #17 in the fa transferred to a local hospital. Resident #11 hospital for evaluation incident report reveal (CNA) #6 (who was a one-on-one) provided indicated she was no Resident #13 started face. Resident #17 was NJ A facility incident report 11:10 AM reported CI statement which indic	ad he thought the physician needed two diagnoses, and him. The Administrator ember when he spoke with ehavior unit. He said when out to the crisis center, the esident a few hours. Then it back to the facility, and the ake the resident back. Is asked to provide empts to provide placement tated everything was verbal. entation of anything. Out dated 08/08/2021 at esident #13 repeatedly hit right side of the face. This he activities/dining room. served to stand up, 17 and start punching ace. Resident #13 was crisis center at a local 7 was transferred to a local h and treatment. The ed Certified Nurse Aide ssigned to provide I a written statement which t with Resident #13 when hitting Resident #17 in the	F	689			

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	2: 02/23/2023 APPROVED 0: 0938-0391
STATEMENT C	DEFICENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		315280	B. WING		_	08/ [,]	C 13/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
SILVER HI	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 SC IDENT FY NG INFORMATION)	D PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 689	Continued From page Resident #17 in the fa On 08/08/2021 at 11:3 stated CNA #6 had be one-on-one for Reside On 08/08/2021 at 4:19 returned from the hos sitting in the dining/ac On 08/09/2021 at 10:0 #1, #7, and #8) who p Resident #13 stated to unpredictable. There would set the resident too close, the resident other resident. If a resi resident would strike of resident. Resident #13 residents to be near. 3 just did not like the wa at the resident. Resident On 08/09/2021 at 11:2 physician was contact was on vacation, he of record with him, and h anything. On 08/09/2021 at 2:00 the DON (Director of I physician's order did n	 a 31 ace. 30 AM, Unit Manager #3 ben assigned to provide ent #13. 5 PM, Resident #17 had pital and was observed trivity room. The NEWE Order 26:46.1 00 AM, three CNAs (CNAs provided direct care for he resident was was no way to predict what t off. If another resident got t would jump up and hit the sident walked by, the out and hit the other 3 did not like for other Sometimes Resident #13 ay another resident looked ent #13 was very fast. 20 AM, Resident #13's ted by phone. He stated he lidn't have the medical he didn't remember 0 PM, the Administrator and Nurses) both verbalized the not indicate the transfer 	F 689				
	did not tell them to tra immediately. They we	nsfer the resident					

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		D 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 SURVEY COMPLETED C		
		315280	B. WING				_ 13/2021	
NAME OF PI	ROVIDER OR SUPPLIER				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 PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)		(X5) COMPLETION DATE	
F 689 F 756 SS=D	documentation of con Resident #13, such a: they did not have a fo one-on-one, but the ro They we been reviewed, and if put in place after even the resident was alwa New Jersey Administr Drug Regimen Review CFR(s): 483.45(c)(1)(§483.45(c) Drug Regi	stant supervision for s one-on-one. They stated rm that recorded esident was ^{NEwec order 264b1} re asked if interventions had new interventions had been y altercation. They stated ys on ^{NEwec order 264b1} . rative Code § 8:39-5.1(a) w, Report Irregular, Act On 2)(4)(5)		689 756			8/30/21	
	must be reviewed at I licensed pharmacist. §483.45(c)(2) This re- of the resident's medi §483.45(c)(4) The pha- irregularities to the att facility's medical direct and these reports mu (i) Irregularities included drug that meets the cc (d) of this section for a (ii) Any irregularities r during this review mu separate, written repo- attending physician at director and director of minimum, the residen and the irregularity the (iii) The attending phy- resident's medical rector	east once a month by a view must include a review cal chart. armacist must report any tending physician and the stor and director of nursing, st be acted upon. de, but are not limited to, any riteria set forth in paragraph an unnecessary drug. toted by the pharmacist st be documented on a ort that is sent to the nd the facility's medical of nursing and lists, at a t's name, the relevant drug, e pharmacist identified. rsician must document in the						

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		D HUMAN SERVICES MEDICAID SERVICES				INTED: 02/23/2023 FORM APPROVED IB NO. 0938-0391
STATEMENT	DF DEFIC ENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	· /	PLE CONSTRUCTION		3) DATE SURVEY COMPLETED
		315280	B. WING			C 08/13/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	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 SC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLETION DATE
F 756	action has been taker be no change in the n physician should doct the resident's medica §483.45(c)(5) The fac maintain policies and drug regimen review f limited to, time frames the process and steps when he or she identi requires urgent action This REQUIREMENT by: Complaint Intake: NJ Based on observation interviews, it was dete follow up on pharmac (Resident #20) of 3 sa medication passes we potential to affect all r facility. Findings included: 1. Resident #20 had c NJ Exec. Order 26:4 resident's Minimum D recorded the resident of daily living. A physician's order da the resident was to be	to address it. If there is to nedication, the attending ument his or her rationale in record.	F 75	Resident #20 was not adve by this deficient practice. All resident have the potent effected by this deficient pr facility got a stat order that continued ordering regularl To ensure that this does not pharmacy recommendation communicated via email to managers. DON will educat Managers on the process to through with recommendat To monitor the corrective ad will keep copies of recommendation communicate to the MD and recommendation is verified audit the recommendations pharmacy two times a weet contact MDs for any recommendations pharmacy two times a weet contact MDs for any recommendations pharmacy the facility is comported with the pharmacy reviewing these audits by the second second second properly with the pharmacy	tial to be ractice. The day and ly. ot reoccur as will be DON and Unit ate Unit o follow ions. ction: DON rendations and JMs ad the I. DON will s sent by the k and will mendation that within a week, nmunicating y we will be	

Event ID: IV9211

Facility ID: NJ60407

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 02/23/2023 MAPPROVED). 0938-0391	
STATEMENT (DF DEFIC ENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		315280	B. WING			C 08/13/2021		
NAME OF PI	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 PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 756	Continued From page	: 34	Í F	756				
F 756	Nurse (LPN) #6 was or resident's morning me was observed ^{MEacoderas} medication cart. The I was ordered yesterda She stated she would it immediately. She le pharmacy. On 08/07/2021 at 9:4 of Nurses (ADON) wa form that indicated wh been ordered. On 08/07/2021 at 10: a pharmacy review fo indicated the pharmace NJ Exec. Order 26:4. resident's insurance of On 08/07/2021 at 11: a physician's order wh	 bbserved preparing the ediations for Resident #20. It was not on the LPN stated the medication yout was not on the cart. have the pharmacy deliver ft the cart to notify the 5 AM, the Assistant Director is asked if he could find the nen the medication had 30 AM, the ADON provided rm dated 07/24/2021 which cist had recommended b.1, and NJ Exec. Order 26:4.b.1 due to the lid not cover Note: Corder 26:4.b.1 CO AM, the ADON provided the resident and NJ Exec. Order 26:4.b.1 	F	756	meetings for the next 2 quarters. The Director of Nursing will be responsible for this plan of correction, substantial compliance will be achieve 08/30/2021.	d by		
	been here a few days recommendation. He	unit manager had only and was unaware of the added the former unit d on the recommendation						
	of new pharmacy reco	d for the facility naking sure staff was aware ommendations. He stated was a policy, but he would						

Facility ID: NJ60407

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM): 02/23/2023 MAPPROVED). 0938-0391
STATEMENT OF DEFIC ENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENT FICATION NUMBER:			(X2) MULT PLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		315280	B. WING					C 13/2021
NAME OF P	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP C	ODE		
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 PREF TAG	IX	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD B		(X5) COMPLETION DATE
F 756	On 08/07/2021 at 2:3 had been unable to lo ensure pharmacy rec readably available for and act upon.	0 PM, the ADON stated he ocate a policy for how to	F	756				

Facility ID: NJ60407

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POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION		DATE OF REVISIT	
IDENTIFICATION NUMBER	A. Building			
315280 _{Y1}	B. Wing	Y2	9/3/2021	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).

ITEI	м	DATE	ITEM		DATE	ITEM		DATE
Y4		Y5	Y4		Y5	Y4		Y5
ID Prefix Reg. # LSC	F0584 483.10(i)(1)-(7)	Correction Completed 08/30/2021	ID Prefix Reg. # LSC	F0600 483.12(a)(1)	Correction Completed	ID Prefix Reg. # LSC	F0689 483.25(d)(1)(2)	Correction Completed 08/30/2021
ID Prefix Reg. # LSC	F0756 483.45(c)(1)(2)(4)	Correction (5) Completed 08/30/2021	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
REVIEWED BY STATE AGENCY REVIEWED BY (INITIALS) REVIEWED BY CMS RO REVIEWED BY (INITIALS) FOLLOWUP TO SURVEY COMPLETED ON 8/13/2021			SIGNATURE OF TITLE CK FOR ANY UNCORREC DRRECTED DEFICIENCI	CTED DEFICIENCIES				