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

PRINTED: 09/09/2019 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER SILVER HEALTHCARE CENTER SUMMARY STATEMENT OF DEPICIENCIPS (AN) D PREFIX TAG PROVIDERS THAN OF CORRECTION RESOLUTION OR SUPPLIER FOUND INITIAL COMMENTS COMPLAINT #: NJ127162 CENSUS: 188 SAMPLE SIZE: 3 THE FACILITY IS IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PARTAS, SUPPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.	STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING				(X3) DATE SURVEY COMPLETED C	
MAIR OF PROVIDER OR SUPPLIER SILVER HEALTHCARE CENTER OPINIO CHILD C			315280	B. WING		0.0		
PRETIX TAG REGULATORY OR ISC IDENTIFYING INFORMATION) FOOD INITIAL COMMENTS COMPLAINT #: NJ127162 CENSUS: 188 SAMPLE SIZE: 3 THE FACILITY IS IN SUBSTANTIAL COMPLAINCE WITH TREQUIREMENTS OF 42 CFR PARTIAS, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.	NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE 1417 BRACE ROAD			
COMPLAINT #: NJ127162 CENSUS: 188 SAMPLE SIZE: 3 THE FACILITY IS IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		
CENSUS: 188 SAMPLE SIZE: 3 THE FACILITY IS IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.	F 000	INITIAL COMMENTS		FC	F 000			
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THE FACILITY IS IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.		CENSUS: 188						
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		COMPLIANCE WITH 42 CFR PART483, SI TERM CARE FACILI	THE REQUIREMENTS OF UBPART B, FOR LONG					
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE	I A D O D A T O D Y	DIDECTORIS OR PROVINCE	CLIDDLIED DEDDECENTATIVES CLONATU	DE	TITLE		(X6) DATE	

Electronically Signed 08/30/2019

Facility ID: NJ60407

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.