STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315280	A. BUILDING _____ B. WING _____	03/12/2020

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0584 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, it was determined that the facility failed to maintain a clean and sanitary environment. This deficient practice was identified for the Pavilion Unit, 1 of 5 units in the facility, and was evidenced by the following: On 3/5/2020 at 8:25 AM the surveyor observed the following on the B side of the Pavilion unit: 1. There was a solarium style room, with no door, in the corner of the unit between resident rooms [ROOM NUMBERS]. There were large windows with artificial plants hanging from the ceiling. The room contained three, 3-drawer cabinets, 4 free-standing closets, 2 chairs, and 2 unmade beds with stained blue mattresses. The room had a urine odor. There was a heavy accumulation of dirt in the corners and at the floor/wall junctures around the room. 2. There was a large day/dining/activities area outside of resident rooms 413 to 423. There was loose cove base molding in areas around the room, missing cove base molding next to resident room [ROOM NUMBER], missing cove base molding next to resident room [ROOM NUMBER], missing wallboard next to resident room [ROOM NUMBER], and an accumulation of dirt at the floor/wall junctures. 3. There was a solarium style room, with no door, between resident rooms [ROOM NUMBERS]. There was an accumulation of dirt at the floor/wall junctures and in the corners. There was wall damage by the exit doorway that leads to the outside of the building. There was a ceiling tile near the exit door that had a dried brown stain over the entire tile, which was bulging downward. 4. There was a section of the cove base molding lying on the floor next to res room [ROOM NUMBER]. 5. There was a section of wooden molding missing at the ceiling area above resident room [ROOM NUMBER]. 6. There were splatters of a dried brown substance on a pillar by the back entrance to the nurse's station. 7. A large ceiling vent above the television on the B side had a heavy accumulation of dust. 8. The bases on 6 of 6 dining tables were scuffed and had dried food spills and dirt. 9. A blue dining chair had a dried, brown substance on the surface and side of the seat cushion. The surveyor observed this same chair on [DATE]20 at 9:25 AM, with the spillage still present. 10. The wooden frame under the seat cushion of 2 red dining chairs was dusty. A non-interviewable resident was seated in one of the chairs, eating breakfast. The surveyor observed 2 red chairs on [DATE]20 at 9:25 AM with the dust still present. A non-interviewable resident was seated in one of the red chairs being assisted with breakfast by a staff member. 11. There was a build-up of dirt in the corners and at the floor/wall junctures in the Central Bathing room across from resident room [ROOM NUMBER]. There was a brown substance in areas of the grout between the tiles in the shower stall, wet from a shower being given, in the Central Bathing room across from resident room [ROOM NUMBER]. On 3/10/20 between 8:25 AM and 9:02 AM, the surveyor observed the following: 1. There was loose, torn, and stained wallpaper in resident room [ROOM NUMBER]. There was no toilet paper rod in the bathroom. The roll of toilet paper was sitting on the toilet tank. There was no trash can in the bathroom; there was a pile of used/wet paper towels on the floor under the sink. There was a build-up of dirt in the corners and at the floor/wall junctures around the room. 2. There was wall damage below the sink in resident room [ROOM NUMBER]. There was no trash can in the bathroom. The toilet bowl contained a large amount of paper towels. There was a build-up of dirt in the corners and at the floor/wall junctures around the room. 3. There were 4 missing floor tiles in the bathroom in the resident room [ROOM NUMBER]. There was damage to the inside of the bathroom door. There was a build-up of dirt in the corners and at the floor/wall junctures around the room. 4. The wallpaper was peeling off of the wall below the bathroom sink in resident room [ROOM NUMBER]. There was an accumulation of dust in the bathroom ceiling vent. There was a build-up of dirt in the corners and at the floor/wall junctures around the room. On 3/5/2020 at 8:49 AM, the surveyor observed an area between an exit door to the outside and the side of the nurse's station. This area included a locked Family Room, the Activities Office, a Restroom, and vending machines. There was wall damage near the floor next to the restroom door. There was an accumulation of dirt at the floor/wall junctures and in the corners. On 3/5/2020 at 8:52 AM, the surveyor interviewed a housekeeping employee who was on the B side of the unit. When interviewed, the housekeeping employee said there were usually 2 housekeepers on the unit, and they worked 7 AM to 3 PM. The housekeeping employee said there was no one from housekeeping that worked after 3 PM. They were only here one shift. The housekeeping employee also said, I believe there's a floor tech in the building, though. When asked what the procedure was for cleaning the unit, the housekeeping employee said, when we get to the unit, we set up the cart, get water, and start with the nurse's station. We empty the trash, wipe counters, and mop the floor. We clean the breakroom for the employees. Then we come out and mop floors in bathrooms and shower rooms, wipe down sink and toilet, and empty trash. Then we start the rooms (the resident rooms), we do about 10 to 12 rooms daily. We empty the trash, wipe down the dressers, wipe the blinds, wipe the windowsills, wipe the sinks and toilets, dust the lights, and sweep and mop the floor. On 3/5/2020 at 9:36 AM, the surveyor observed the A-side of the unit and observed the following: 1. There was a build-up of dirt in the corners and at the floor/wall junctures around the day/dining/activities area, and a heavy build-up in the alcove where the chair scale was. The base of the chair scale was very dirty in appearance. 2. There was a heavy accumulation of dust in the ceiling vent outside of resident room [ROOM NUMBER]. 3. The bases on 7 of 7 black dining/activity tables were dusty. (The black tables were a different style than the tables on the B side.) There was one table on the A-side that was the same style as the B side tables. The base of this table was scuffed. 4. There was a heavy accumulation of dust in the ceiling vent in the aquarium- decorated sitting area by the entrance to the unit. 5. There was an island area at the side of the A day/dining/activities area. The island was open in the middle with access via a short, gate-style swing door latched closed from the inside. The white countertop around the inside of the island had red and brown stains. The doors on the cabinets did not fit properly and were hanging down. There was a build-up of dirt at the floor/wall junctures inside of the island. There were dried stains on the inside of the swing door. When interviewed on 3/5/2020 at 9:48 AM, an activities staff member said, we use the island when I cook. I cook and put things on the counter for the residents to eat. On 3/5/2020 at 10:45 AM, the surveyor interviewed the Environmental Service Director (ESD), who said he had started in the position on 1/10/2020. The ESD said before that, the facility had an outside company for housekeeping services. When asked about the Pavilion unit, the ESD said every housekeeping cart had a housekeeping book on it, which directed the housekeepers for what to do on that specific unit. The ESD said, for Pavilion, the cart would be labeled Pavilion, and the book would go with that cart. The ESD said there were 2 housekeeping employees for the pavilion unit daily, 7 days a week. The ESD said, I'm in the process of beefing up the housekeeping staff, the previous company was short on staff. The ESD said, even if someone calls out, I still try to keep 2 in the Pavilion due to what we face over there. Behaviors from the residents, more spills, bathroom issues. When asked about the Pavilion unit, the ESD said, It's not where I'd like it to be, but we are trying to improve. It's definitely outdated. The surveyor asked the ESD for a copy of the procedure that was on the housekeeping cart in the Pavilion, which was provided to the surveyor at 12:14 PM. Upon review, the surveyor observed a one-page Cleaning Guidelines sheet which noted the following in its entirety: 1. Fill up a mop bucket with fresh water on the assigned unit. 2. Start Daily Cleaning

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315280	A. BUILDING _____ B. WING _____	**03/12/2020**

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0584 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) at Nurses Station at assigned site. 3. Clean the Unit Employee Break Room. 4. Clean Unit Shower Room. 5. Clean Unit Common Bathrooms. 6. As soon as the last Food Cart is off the floor, start cleaning the assigned rooms. NJAC 8:39-31.4(a)
F 0641 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Ensure each resident receives an accurate assessment.** Based on interview and record review, it was determined that the facility failed to complete an accurate Minimum Data Set (MDS), an assessment tool. This was cited at a level E as the deficient practice was identified for 6 of 37 residents. This deficient practice was identified for 6 of 37 residents reviewed (Residents #5, #13, #79, #119, #127, #142), and was evidenced by the following: 1. On 3/4/2020 at 10:03 AM, the surveyor observed Resident #13 in a wheelchair. Both of the resident's knees were contracted. When asked, Resident #13 could not straighten his/her legs. The surveyor reviewed the [DATE] Quarterly MDS for Resident #13. The section for Functional Limitation in Range of Motion was coded as 1, indicating there was range of motion impairment of the lower extremity on one side. When interviewed on [DATE]20 at 9:50 AM, the MDS Coordinator acknowledged that Resident #13 had contractures of his/her bilateral lower extremities, which should have been coded on the 0[DATE] Quarterly MDS. 2. The surveyor reviewed the 1/17/2020 significant change MDS for Resident #119 and observed that the resident was coded as hospice care. During a review of the medical record, the surveyor observed that the resident was not on hospice at that time. When interviewed on 3/11/2020 at 10 AM, the MDS Coordinator stated the resident was currently on hospice. (The resident was not currently on hospice.) On 3/11/20 at 11:54 AM, the surveyor interviewed the MDS Coordinator again. The MDS Coordinator stated, We did know she was coming off hospice on 1/7/2020, which was the last covered day and provided the discharge notification from the billing services company, which was signed 1/7/2020. The MDS Coordinator stated, That was coded incorrectly. 3. The surveyor reviewed the 2/16/2020 quarterly MDS of Resident #5 and observed that the MDS noted the resident did not receive antipsychotic medications on any of the reviewed days but was also marked Yes - Antipsychotics were received on a routine basis only. When interviewed on [DATE]20 at 2:38 PM, the MDS Coordinator stated the coding was incorrect because the resident did not receive antipsychotics during the review period. 4. The surveyor reviewed the [DATE] quarterly MDS of Resident #79 and observed that it noted the resident did not receive antipsychotic medications on any of the reviewed days but was also marked Yes - Antipsychotics were received on a routine basis only. When interviewed on [DATE]20 at 2:38 PM, the MDS Coordinator stated the coding was incorrect because the resident did not receive antipsychotics during the review period. 5. The surveyor reviewed the 1/15/2020 quarterly MDS of Resident #127 and observed the resident did not receive antipsychotic medications on any of the reviewed days but was also marked Yes - Antipsychotics were received on a routine and (as needed) basis. When interviewed on [DATE]20 at 2:38 PM, the MDS Coordinator stated the coding was incorrect because the resident received an antipsychotic medication twice during the review period. 6. On 3/4/2020 at 10:02 AM, the surveyor observed Resident #142 lying in bed. He/she was awake, alert, and answered questions appropriately. The surveyor reviewed the 1/28/2020 quarterly MDS of Resident #142 and observed it did not include the staff's assessment to determine the resident's cognition. The MDS also included that the resident did not receive antipsychotic medications during the review period, but was also marked Yes - Antipsychotics were received. When interviewed on [DATE]20 at 2:31 PM, the Social Worker stated that she should have completed the Staff Assessment for Mental Status section of the MDS, but she hit the wrong button which was done in error. When interviewed on [DATE]20 at 2:38 PM, the MDS Coordinator stated the resident did not have any antipsychotic medications ordered, and the coding was incorrect. NJAC 8.39-11.1
F 0656 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, it was determined that the facility failed to follow the resident's established care plan that was in place to address concerns identified by the interdisciplinary team. This deficient practice was identified for 2 of 35 residents (Residents #7 and #161) whose care plans were reviewed, and was evidenced by the following: 1. Resident #7 had [DIAGNOSES REDACTED]. The annual 2/19/20 Minimum Data Set, an assessment tool, identified that the resident was severely cognitively impaired, required extensive staff assistance with activities of daily living, and had not triggered a weight loss or gain. A 2/21/2020 Annual Nutrition Assessment, completed by the Dietitian, included that the resident's weight is trending down. The note also included that resident constantly wandering/ambulating around the unit and that the weight loss may also be attributed to deterioration of disease process. The Dietitian also noted that the weight loss was undesirable but not clinically significant. The Dietitian wrote, weight maintenance is goal. The surveyor reviewed a 3/11/2020 Nutrition Progress Note (PN), written by the Dietitian, that included resident has good PO (by mouth) intake for fortified foods (super cereal and super mashed potatoes). The PN also included Diet: Regular/Mechanical Soft Texture/Thin Liquids +fortified foods at all meals. The surveyor reviewed the resident's care plan and observed that it included a Focus of I am at nutritional risk, and the interventions included provide diet as ordered and fortified foods at all meals. On 3/5/2020 at 8:50 AM, the surveyor observed Resident #7 at the breakfast meal. Super cereal was listed on the resident's meal tray ticket. The super cereal was not sent to the resident. On 3/10/2020 at 8:15 AM, the surveyor observed Resident #7 at the breakfast meal. Super cereal was listed on the resident's meal tray ticket. The super cereal was not sent to the resident. On 3/11/2020 at 12:46 PM, the surveyor observed Resident #7 at the noon meal. Super mashed potatoes were listed on the resident's meal tray ticket. The super mashed potatoes were not sent to the resident. 2. The surveyor reviewed the medical record of Resident #161 and observed that the resident had [DIAGNOSES REDACTED]. The 2/4/2020 Minimum Data Set identified that the resident was severely cognitively impaired. On 3/4/2020 at 10:07 AM, the surveyor observed Resident #161 lying in bed. An Occupational Therapist (OT) was working with the resident. When interviewed at that time, the OT said she was working with the resident's hand contractures and hygiene of the hands. The surveyor observed a palm guard in the resident's contracted right hand. The surveyor observed that the resident's left hand was severely contracted. The surveyor observed the OT using gauze that she was getting into the contracted hand to cleanse the palm. During a review of the medical record, the surveyor observed that the physician signed, 3/2020 physician's orders [REDACTED]. The resident's care plan also addressed the use of hand devices under a Focus area of (Resident) has decreased ROM (Range of Motion) in left shoulders and left elbow and bilateral hands and has splint not fitting appropriately. The Goal was (Resident) will demonstrate increase in ROM and tolerate splint (Hand Roll) to the Right hand for 8 hours as tolerated, Left Hand wash positioning device between the palm and fingers. On [DATE]20 at 10:21 AM, the surveyor observed the resident lying in a recliner in the unit day area. There was nothing in either of the resident's hands. On 3/10/2020 at 8:15 AM, the surveyor observed the resident lying in bed. According to the orders, the resident should have had a rolled soft washcloth in the left hand. There was nothing in the resident's left hand. On 3/10/2020 at 2:15 PM, two surveyors observed the resident lying in a recliner in the unit day area. There was a palm guard in the resident's right hand. There was nothing in the resident's left hand. On 3/11/2020 at 12:30 PM, the surveyor observed the resident lying in a recliner in the unit day area. There was a palm guard in the resident's right hand. There was nothing in the resident's left hand. NJAC 8:39-11.2(d)
F 0658 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, it was determined that the facility failed to follow acceptable standards of clinical practice with medication administration, obtaining physician's orders [REDACTED]. This was cited at a level E as the deficient practice was identified for 3 of 35 residents on 2 of 5 units. This deficient practice was identified for 3 of 35 residents (Residents #109, #127, and #142) reviewed for professional standards, and was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as casefinding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist. Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315280	A. BUILDING _____ B. WING _____	03/12/2020

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of casefinding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist. 1. The surveyor reviewed the medical record of Resident #109 and observed a [DATE] physician's orders [REDACTED]. There was no corresponding PO for the [MEDICATION NAME] to be administered after 1/11/2020. Upon review of the January 2020 Medication Administration Record [REDACTED]. The resident's Individual Patient Controlled Substance Administration Record for the [MEDICATION NAME] from 1/5/2020 through 2/13/2020 included that [MEDICATION NAME] had been administered 107 times after 1/11/2020 until a new order was received on 2/13/2020. During an interview on 3/10/20 at 12:54 PM, the Registered Nurse (RN) in charge of the unit said no reevaluation had been done on 1/11/2020. The RN could not find an order for [REDACTED]. 14 days which means that a new order shall be received and transcribed to MAR/TAR as a new order, and a new order date shall be transcribed. 2. On 3/10/2020 at 8:17 AM, the surveyor observed the RN administer four medications via a gastrostomy tube to Resident #127. The resident was lying with his head at the foot of the bed, and the resident's head was not elevated. When interviewed on 3/10/2020 at 8:55 AM, the RN stated the resident's head should have been elevated 30 to 45 degrees during medication administration. Still, for this resident, it was impossible because of how (Resident #127) moves in the bed. During an interview on 3/10/2020 at 1:11 PM, the Licensed Practical Nurse (LPN) in charge of the unit stated that during med pass, all residents should have their head elevated 30 to 45 degrees and that it would not be impossible for Resident #127 to be positioned this way. The LPN further stated that it was necessary to properly position residents before medication administration to prevent aspiration (liquid in the lungs). In a meeting with the survey team on 3/12/20 at 9:13 AM, the Director of Nursing stated it is never safe to give medications while the resident is lying flat due to the risk for aspiration. Review of the facility's Medication Administration policy revised 12/2019 included, Resident to be properly positioned to receive medications (e.g., head of bed is elevated at an angle of 30-45 degrees. 3. On 3/4/2020 at 10:02 AM, the surveyor observed Resident #142 lying in bed in a pleasant mood. The surveyor reviewed the resident's medical record and observed a [DATE]20 physician's orders [REDACTED]. The resident's 2/2020 MAR indicated [REDACTED]. The surveyor observed that nurses' signatures for the administration of the medication were recorded six times after the stop date. The resident's Controlled Substance Administration Record for [MEDICATION NAME], dated 2/20/2020, noted that the medication was dispensed 12 times after 2/20/2020. During an interview on 3/5/2020 at 10:13 AM, the LPN in charge of the unit looked in the resident's chart and could not find an order for [REDACTED]. During an interview on 3/5/2020 at 11:33 AM, the Director of Nursing stated there wasn't an order for [REDACTED]. if warranted. NJAC 8:39-11.2(b) NJAC 8:39-27.1 (a)
F 0688 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, it was determined that the facility failed to provide hand devices that had been ordered to prevent further decline in a resident's range of motion. This deficient practice was identified for 1 of 2 residents reviewed (Resident #161) for positioning/range of motion and was evidenced by the following: The surveyor reviewed the medical record of Resident #161 and observed that the resident had [DIAGNOSES REDACTED]. The 2/4/2020 Minimum Data Set, an assessment tool, identified that the resident was severely cognitively impaired. On 3/4/2020 at 10:07 AM, the surveyor observed Resident #161 lying in bed. An Occupational Therapist (OT) was working with the resident. When interviewed at that time, the OT said she was working with the resident's hand contractures and hygiene of the hands. The surveyor observed a palm guard in the resident's contracted right hand. The surveyor observed that the resident's left hand was severely contracted. The surveyor observed the OT using gauze that she was getting into the contracted hand to cleanse the palm. During a review of the medical record, the surveyor observed that the Physician signed, 3/2020 physician's orders [REDACTED]. The resident's care plan also addressed the use of hand devices under a Focus area of (Resident) has decreased ROM (Range of Motion) in left shoulders and left elbow and bilateral hands and has splint not fitting appropriately. The Goal was (Resident) will demonstrate increase in ROM and tolerate splint (Hand Roll) to the Right hand for 8 hours as tolerated, Left Hand wash positioning device between the palm and fingers. On 3/6/2020 at 12:41 PM, the surveyor observed the resident lying in a recliner in the unit day area. There was nothing in either of the resident's hands. On [DATE]20 at 10:21 AM, the surveyor observed the resident lying in a recliner in the unit day area. There was nothing in either of the resident's hands. On 3/10/2020 at 8:15 AM, the surveyor observed the resident lying in bed. According to the orders, the resident should have had a rolled soft washcloth in the left hand. There was nothing in the resident's left hand. On 3/10/2020 at 2:15 PM, two surveyors observed the resident lying in a recliner in the unit day area. There was a palm guard in the resident's right hand. There was nothing in the resident's left hand. On 3/11/2020 at 12:30 PM, the surveyor observed the resident lying in a recliner in the unit day area. There was a palm guard in the resident's right hand. There was nothing in the resident's left hand. When interviewed at that time, the unit Licensed Practical Nurse (LPN) said she had the resident that day, and nurses put hand rolls on residents. When the surveyor told the nurse, there was nothing in the resident's left hand. The LPN said, ok. The surveyor asked the LPN if she knew what the order was for hand devices. The LPN said, I have to look it up, and then went to look at the Treatment Administration Record. The LPN then said, I haven't done anything with (him/her) today, (he/she) just came out. The LPN said, I'll go see if there's a washcloth in (his/her) drawer. The LPN went into the resident's room and took a washcloth out of a dresser drawer. The LPN said, I will put it in (his/her) hand now. During a follow-up meeting on 3/12/2020 at 9:15 AM, the Director of Nursing confirmed that the resident should have been wearing the devices as ordered on the current physician's orders [REDACTED]. NJAC 8:39-27.1(a)
F 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, it was determined that the facility failed to maintain an indwelling urinary catheter according to the facility policy. This was identified for 1 of 5 residents (Resident #62) reviewed for indwelling urinary catheters. This deficient practice was evidenced by the following: The surveyor reviewed the medical record and observed Resident #62 had [DIAGNOSES REDACTED]. The surveyor reviewed the 12/22/19 Minimum Data Set (MDS), an assessment tool, and observed that the resident was identified as having an indwelling urinary catheter and occasional bowel incontinence. The MDS also identified Resident #62 as severely cognitively impaired. The resident's current care plan, revised 3/10/20, noted that the resident had an indwelling urinary catheter-related to neuromuscular dysfunction with interventions that included to position the catheter drainage bag and tubing below the level of the bladder, put drainage bag in a privacy bag at all times and monitor for signs of UTI. The 2/10/20 physician's orders [REDACTED]. The drainage bag was on the door side of the resident's bed and could be observed from the doorway. In addition, the resident's room had a strong smell of urine. On 3/5/20 at 8:33 AM, the surveyor observed the resident's urinary catheter drainage bag and tubing lying on the floor on the door side of the bed. During a further review of the medical record, the surveyor observed that the resident had been diagnosed with [REDACTED]. On 3/5/20 at 12:40 PM, the surveyor observed the resident in bed with the catheter drainage bag hanging on the side of the bed by the door. The catheter drainage bag was partially out of the privacy cover, not touching the floor, but could be seen from the doorway with urine visible. On 3/5/20 at 1:08 PM, the surveyor observed the urinary catheter drainage bag hanging from the side of the bed (doorway side), halfway out of the privacy bag. The catheter drainage bag could be observed from the hallway, and urine was visible in the bag. On 3/6/20 at 9:25 AM, the surveyor observed the resident's catheter drainage bag hanging from the side rail of the bed with the tubing and collection bag touching the floor. On 3/6/20 at 10:42 AM, the surveyor observed Resident #62's catheter drainage bag and tubing still touching the floor from the earlier observation. The catheter drainage bag was hanging partially out of the privacy bag. The urine was visible from the doorway. On 3/6/20 at 1:09 PM, the surveyor observed the resident's spouse visiting the resident and stepping on the catheter tubing, which was lying on the floor next to the bed. On [DATE] at 9:31 AM, the surveyor observed the catheter drainage bag lying flat on the floor. On [DATE] at 9:40 AM, the surveyor interviewed the Registered Nurse (RN) and the Certified Nursing Assistant (CNA) responsible for the resident's care. The RN stated, I

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315280	A. BUILDING _____ B. WING _____	03/12/2020

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) hooked it up to the bed this morning at about 9:15 AM. It must have fell (sic) off the bed from the resident moving. The CNA stated, Sometimes they don't hook it to the bed right, and it falls off. The RN hooked it up to the bed today. The CNA stated he usually emptied the catheter drainage bag and hooked it back to the side of the resident's bed. On [DATE] at 12:45 PM, the Administrator provided the surveyor with the facility policy Policy and Procedures: Catheters with revision date 10/4/19. The policy included the following: Unobstructed urine flow should be maintained at all times. The catheter and collecting tubing should be kept from kinking, and the collection bag should always be kept below the level of the bladder (and not touching the floor). And Hang the collection bag below the level of the bladder to prevent urine reflux into the bladder, which can cause infection. Tubing should not drag on the floor or be lower than the bag. NJAC 8:39-19:4(a)(1-6)
F 0692 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, it was determined that the facility failed to provide a resident with nutritional interventions that were recommended for a resident with nutritional concerns. This deficient practice was identified for 1 of 5 residents (Resident #7) who were reviewed for nutrition and was evidenced by the following: Resident #7 had [DIAGNOSES REDACTED]. The annual 2/19/20 Minimum Data Set, an assessment tool, identified that the resident was severely cognitively impaired, required extensive staff assistance with activities of daily living, and had not triggered a weight loss or gain. A 2/21/2020 Annual Nutrition Assessment, completed by the Dietitian, included that the resident's weight is trending down. The note also included that resident constantly wandering/ambulating around the unit and that the weight loss may also be attributed to deterioration of disease process. The Dietitian also noted that the weight loss was undesirable but not clinically significant. The Dietitian wrote, weight maintenance is goal. The surveyor reviewed a 3/11/2020 Nutrition Progress Note (PN), written by the Dietitian, that included resident has good PO (by mouth) intake for fortified foods (super cereal and super mashed potatoes). The PN also included Diet: Regular/Mechanical Soft Texture/Thin Liquids +fortified foods at all meals and that the resident mostly ate 51 to 100%. The surveyor reviewed the resident's care plan and observed that it included a Focus of I am at nutritional risk, and the interventions included provide diet as ordered and fortified foods at all meals. On 3/5/2020 at 8:50 AM, the surveyor observed Resident #7 at the breakfast meal. The resident was sitting at a dining table, and feeding self scrambled eggs. The resident ate all of the eggs, drank all of the 8 oz whole milk, orange juice, and 8 oz coffee. A Certified Nursing Assistant (CNA) was sitting with the resident and got more orange juice, which the resident also drank all of. There was a piece of toast on the plate which the resident also ate. The meal tray slip noted that the resident was to receive butter, but none had come on the tray. When interviewed at that time, the CNA said no one on the unit had received butter that morning. (The surveyor was told that the kitchen was out of butter in a subsequent interview with the Food Service Director (FSD) on 3/5/2020 at 9:40 AM and that no one had received butter that morning.) When interviewed during the breakfast meal observation, the CNA said the resident will sit long enough to eat and will eat everything, always does, either by self or with our help. The CNA said, I always let (Resident #7) feed themselves for as long as (Resident #7) will do it. The surveyor also observed that the meal tray slip included super cereal, which the resident did not receive. When the surveyor told the Licensed Practical Nurse (LPN) that there was no super cereal, the LPN said she would call the kitchen. A few minutes later, the surveyor observed the CNA feeding the resident Rice Krispies. When the surveyor mentioned to the CNA that the meal tray slip said super cereal, the CNA asked the surveyor what super cereal was. The surveyor told the CNA that super cereal was a fortified cereal that usually looked like oatmeal. The surveyor went back to the LPN and asked if she had called the kitchen. The LPN said, yes. The surveyor then asked the LPN what she specifically had asked for, and the LPN said, super cereal. When the surveyor told the LPN that the kitchen had sent Rice Krispies, the LPN said the resident would eat the Rice Krispies. The surveyor mentioned to the LPN that the resident was supposed to have super cereal. The LPN then asked the surveyor what super cereal was. The surveyor told the LPN that it was a fortified cereal. The LPN said she would call the kitchen again. (The resident did eat all of the Rice Krispies with milk in it.) On 3/5/2020 at 9:40 AM, the FSD approached the surveyor on the nursing unit with a cereal bowl in hand. The FSD said he had brought super cereal and said, they probably brought regular oatmeal before. The surveyor told the FSD that the kitchen initially had not sent any cereal, then sent Rice Krispies and then sent regular oatmeal, which was what he was carrying. The surveyor then asked the FSD why the resident had not received the super cereal from the beginning. The FSD said he would be following up to find out why the meal tray ticket was not followed. The FSD said, we have a protocol for following tickets. On 3/6/2020 at 9:10 AM, the surveyor observed the resident at the breakfast meal. The meal tray ticket included 8 oz of whole milk, the resident received only 4 oz of milk which was consumed. The CNA noted that the tray ticket had 8 oz of milk and said, I'll get one; we have more. The CNA brought back 8 oz of fat-free skim milk and said, there's no more regular milk. The resident drank all of the skim milk. On 3/6/2020 at 12:42 PM, the surveyor observed the resident at the lunch meal. The meal ticket on the resident's tray included a Dinner Roll which the resident did not receive. When questioned about the dinner roll, the Registered Nurse on the unit said, mechanical soft wouldn't get a roll. The resident played with the food for a while but eventually fed themselves everything that was on the tray. When interviewed on 3/11/2020 at 2:08 PM, the FSD said, the rolls are hard from the 3rd party vendor, we can give them a piece of bread with butter as a substitute, the staff knows that. The resident's meal tray had not included a piece of bread. On 3/10/2020 8:15 AM, the surveyor observed the resident ambulating around the unit. At 9:12 AM, the surveyor observed the LPN seat the resident at a dining table. The tray ticket included super cereal, which the resident did not receive. The surveyor mentioned the lack of super cereal to the LPN, who asked a CNA to call the kitchen. Shortly after, a kitchen employee brought the resident a bowl of super cereal. At this meal, the resident refused to eat anything and started to get physically combative when the staff tried to encourage the resident to eat. When interviewed at that time, the LPN said the resident gets moods like that at times. The LPN said they would try to get her to eat something a little later. On 3/11/2020 at 12:46 PM, the surveyor observed the resident at the noon meal. The resident's tray ticket included dinner roll, milk, super mashed potatoes, and frosted cake. The resident did not get any of those 4 items. The resident had received vanilla ice cream instead of the frosted cake. When interviewed on 3/11/2020 at 2:16 PM, the FSD said a whole tray of the cake had been dropped in the kitchen, so some people got substituted with ice cream because they didn't have enough cake. On 3/11/20 at 1:28 PM, the surveyor interviewed the Registered Dietitian (RD) about Resident #7. When asked if he observed the resident at mealtimes, the RD said he had not recently watched the resident at mealtimes, stating the last time was probably in January. The RD said the resident had been a little lethargic (sleepy) and had some behaviors which the RD referred to as agitation. The RD said, nursing was coaxing (Resident #7). When asked if the resident had eaten, the RD said, it took a while, but yes. The RD further said, from documentation and what I've seen in the past, it (resident's intake) can be variable, but a lot of times (Resident #7) does eat. When asked why he recommended the fortified foods, the RD said, because (Resident #7) weight has kinda been going down, to even out the weight loss. The RD calculated the resident's weights and said the resident had not experienced a significant weight loss. The surveyor told the RD that the resident had received vanilla ice cream that day for lunch instead of the frosted cake. When asked about the difference between vanilla ice cream and frosted cake, the RD said the cake with icing would be better calorie-wise than ice cream. When asked, the RD said he did tray audits monthly to ensure tray accuracy and correct texture. The RD said the last tray audit he had done was on 3/6/2020, and he had not observed any inaccuracies. On 3/5/2020 at 10:15 AM, the FSD provided the surveyor with a policy on Accuracy and Quality of Tray Line Service with Effective or Revised Date 1/17/2019. Upon review, the surveyor observed that the policy included -all trays are checked by food service personnel for accuracy. Trays are also checked by the employees serving the trays before giving the tray to the individual. -the tray is checked to ensure that foods are served as listed on the menu. -Each tray will be checked for: correct name, room number and diet order and accuracy of following menu items. -Problems with tray accuracy are resolved immediately. NJAC 8:39-27.1(a)
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, it was determined that the facility failed to maintain kitchen sanitation in a safe and consistent manner in order to prevent food borne illness. This deficient practice was evidenced by the following: On 3/4/2020 from 8:34 AM to 9:50 AM, the surveyor, accompanied by the Food Service Director (FSD), observed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315280	A. BUILDING _____ B. WING _____	03/12/2020

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0812 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 4) the following in the kitchen: 1. Upon entrance to the kitchen the surveyor observed a Dietary Aide (DA) in the coffee area. The DA had a lengthy goatee. The DA had no beard guard and the goatee was exposed. On interview the FSD stated, Any employee with lengthy facial hair is required to wear a beard net. 2. In the paper product storage area on a lower shelf, a cleaned and sanitized chafing pan had a plastic serving spoon on the inside of the pan. The pan was not inverted and the plastic ladle had an unidentified yellow substance on the serving surface. The FSD stated, that's trash. The FSD threw the ladle in the trash. 3. On a middle shelf in the dry ingredient room [ROOM NUMBER] cans of shredded sauerkraut were labeled with a received date of 1/5. All 4 cans had a best by date of [DATE]. On interview the FSD stated, we just got those in January. I'm gonna keep them and call my rep. They wont be used for resident meals. On the same shelf a can of pear halves had a significant dent on the upper seam. The FSD stated, I'm gonna put that with the other dented cans in the designated dented can area. The FSD put the can of pears in the designated dented can area. 4. In the reach-in refrigerator a third pan on an upper shelf contained diced turkey. The pan had no date. The FSD stated, We cut that up last night for today's lunch. They forgot to date it. 5. In the walk-in refrigerator on top of a multi-tiered mobile cart, a plastic tray contained 15 individually prepared vanilla puddings. The puddings were made 2/22/20 and had a Discard by date of 2/27/20 at 8PM. The FSD stated they're out of date. The FSD threw the puddings in the trash. 6. On a lower shelf in the walk-in refrigerator, a sheet pan contained two 10 pound logs of ground beef. The logs/sheet pan had no dates to identify when the meat was pulled to defrost and had no use by dates. On interview the FSD stated they were pulled to thaw on Monday and were to be used for Wednesday for meat loaf. The FSD stated, I need to get a system in place to identify the pull and use by dates. In addition, on a middle shelf an opened plastic bag contained shredded chicken. The bag had no dates. The FSD stated I'm gonna discard it, that should have been dated. The FSD threw the shredded chicken in the trash. 7. A cleaned and sanitized stand up mixer in front of the walk-In refrigerator/freezer had an unidentified yellow substance on the housing and splash guard. The FSD instructed the cook to reclean and sanitize the stand up mixer. 8. In the walk-in freezer 2 bags of frozen collard greens were removed from their original container. The 2 bags of collard greens had no dates. On interview the FSD stated, They were received Friday. They should be dated when removed from their original container. There were no signs of spoilage. In addition, an opened box in the rear of the refrigerator contained frozen cut corn. The box was opened and the corn was exposed. The FSD stated that should be closed. The FSD threw the box of corn in the trash. 9. The FSD and surveyor observed the Dish Machine Log dated 2 Month/Year 2020. The log was not completed for breakfast and dinner on 2/26/20. The log was not completed for breakfast, lunch and dinner for the following dates: 2/27/20, 2/28/20, and 2/29/20. On interview the FSD stated, You see what I see. I'm not trying to be funny but it didn't get done. It's a low temperature machine, does it matter? The surveyor then asked the FSD to provide the March 2020 copy of the Dish Machine Log. The FSD left the office to retrieve the 3/20 Dish Machine Log. After approximately 1 minute the surveyor left the FSD office and returned to the kitchen. Upon entry to the kitchen, the surveyor observed the FSD and DA writing on the 3/20 Dish Machine Log. The surveyor requested to see the copy of the log. Observation of the log revealed the following: there were no SAN READ (sanitizer reading) for the dates 3/1-3/4/2020. There were no WASH TEMP (wash temperature) recorded at the lunch meal for the 3/1-3/4/20. In addition, there were no signatures under the SIGN column for the Lunch column dated 3/1-3/4/20. A review of the Dinner column revealed that a WASH temperature was not recorded on 3/4. The Rinse TEMP was not recorded for the period 3/1-3/4/20. The SAN READ was not recorded for the period 3/1-3/5/20. No SIGN was recorded for the period 3/1-3/4/20. The FSD stated on interview, It is our policy to check and record temperatures and sanitizer levels before we start washing dishes. We are not doing it thoroughly. 10. On a counter in the prep area, a cleaned and sanitized meat slicer contained unidentifiable food debris on the back side of the slicing board. The meat slicer was not in use at the time, had no cover, and was exposed. The surveyor observed the FSD instruct staff to reclean and sanitize the meat slicer. On 3/5/20 from 11:32 AM to 12:03 PM, the surveyor, accompanied by the DA, observed the following on the Subacute Atrium Dining Room: 1. On a prep/serving area table between the cold and hot steam tables the surveyor observed a cleaned and sanitized plate that was to be used to serve residents at the lunch meal that day. The surveyor observed one plate to have a significant chip on the edge of the plate. On interview the DA stated, That shouldn't be used because it has a chip in it. Further observation noted two additional cleaned and sanitized plates that had unidentified food debris on the eating surface of the plate. On interview the DA stated, Oh yeah, I see that. I grabbed these out of the rack of clean dishes in the kitchen. The DA removed the chipped and dirty plates from the stack of dishes. Further observation of the cleaned and sanitized plates noted that they were not in an inverted position and the eating surface of the plates was exposed. On interview the DA stated, I was not aware of that. I will keep them inverted prior to use from now on. On [DATE] from 11:19 AM to 11:27 AM, the surveyor, accompanied by the Licensed Practical Nurse (LPN), observed the following on the Vent Unit: 1. A brown paper bag dated 2/28/20 was observed in the dorm style refrigerator. The bag was labeled with a resident's name and appeared to contain Asian takeout food. The surveyor interviewed the LPN on how long food from the outside of the facility can be stored in the refrigerator. The LPN responded, I think 48 hours. That needs to be thrown away it's been in here too long. The LPN threw the food in the trash. On 3/11/20 from 11:12 AM to 11:47 AM, the surveyor, accompanied by the Cook Supervisor (CS), observed the following in the kitchen: 1. There were two 55 gallon drums in the designated facility garbage area; one drum was covered with a metal lid and the other drum, that contained what appeared to be used cooking oil, was opened and exposed. The drum was labeled Kitchen Grease Only. The ground surrounding the drum and the trash compactor area was black and appeared to be oily/greasy. The CS stated, That oil drum shouldn't be stored like that, it will attract rodents. The grease should be stored away from here. This area needs to be cleaned up. 2. The surveyor observed a Gold Medal trash dumpster in the parking lot. The dumpster contained bags of trash that filled the dumpster to the top. The dumpster had no cover to contain the trash. On interview the CS stated, This isn't our kitchen trash, I don't know where this came from, all this doesn't belong here. On 3/10/2020 at 12:17 PM, the surveyor interviewed the FSD. On interview the FSD stated, The dumpster out back doesn't belong to us. It belongs to the detox center next door. I don't know why it is on our property. The FSD further stated, I'm gonna call the company and get them to come and take that grease. It should have been covered last night because we changed the fryer oil last night. 3. The area surrounding the trash compactor and kitchen grease storage was littered with cardboard, plastic bags, and rubber gloves. The CS stated, This area shouldn't be like this. We need to get it cleaned up. 4. In the walk-in freezer on an upper shelf, a plastic bag contained individual frozen cookie dough that was dated 3/15. The bag was opened and the cookie dough was exposed. The CS stated, Those shouldn't be stored like that. The CS removed the cookies from the freezer and threw the cookies in the trash. 5. The surveyor observed a DA wash her hands at the designated hand washing sink. The DA wet her hands and applied soap. The DA performed vigorous hand washing for 13 seconds then rinsed her hands under running water. The DA then obtained a hand towel and dried her hands, then turned off the water with the hand towel. The DA then threw the hand towel in the trash. 6. On the top of a wire storage rack, a beverage pitcher was filled approximately 1/3 of the way with a yellowish/green liquid. The pitcher was covered on top with plastic wrap. The beverage pitcher had the following label written in what appeared to be black marker Bleach Don't. The rest of the writing was not legible. The CS stated, I'm throwing that whole thing away. Chemicals shouldn't be stored in a beverage pitcher. (The chemical storage room was a locked room and could only be opened by a key). The surveyor reviewed the MIMA Healthcare facility policy titled Guidelines for Foods Brought from the outside by Family and Visitors, effective or revised date 1/17/2019. The policy noted the following at 6 and 7: 6. Perishable foods must be stored in re-sealable containers with tight fitting lids in the refrigerator. Containers will be labeled with resident's name, the items and the use by date. The use by date should be 5 days after food is brought in. 7. Nursing staff is responsible for discarding perishable foods on or before the use by date.' The surveyor reviewed the MIMA Healthcare facility policy titled Food Storage, effective or revised date 1/17/2019. Under the Procedures section the policy noted the following: 5. Chemicals must be clearly labeled, kept in original containers when possible, and kept in a locked area and stored away form food. 8. (d.) Date marking to indicate the date or day by which a ready-to-eat, potentially hazardous food should be consumed, sold or discarded will be visible on all high risk food (see chart on next page). 8. (e.) Foods will be stored and handled to maintain the integrity of the packaging until ready for use. (Food stored in bins may be removed form its original packaging). 13. Leftover food is stored in covered containers or wrapped carefully and securely. Each item is clearly labeled and dated before being refrigerated. Leftover food is used within 5 days or discarded. (Also see policy on Use of Leftovers in this section.) 14. Refrigerated Food Storage: (f.) All foods should be covered, labeled and dated. All foods will be checked to assure that foods (including leftovers) will be consumed by their safe use by dates, or frozen (where applicable) or discarded. 15. Frozen Foods: f. Frozen meat, poultry and fish should be defrosted in a refrigerator for 24 to 48 hours, and should be used immediately after thawing. g. All foods should be covered, labeled and dated. All foods will be checked to assure that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315280	A. BUILDING _____ B. WING _____	03/12/2020

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 5) foods will be consumed by their safe use by dates or discarded. All foods should be checked so as to show no negative outcome (e.g., freezer burn, foods dried out, foods with a change in color). The surveyor reviewed the MIMA Healthcare facility policy titled Dish Machine Temperature Log, effective or revised date 1/17/2019. The policy noted the following under the Policy section: Dishwashing staff will monitor and record dish machine temperatures to assure proper sanitizing of dishes. In addition the policy noted the following under the Procedure section: 1. The food service manager will provide the dishwashing staff with a log to be posted near the dish machine (See sample form next page). 2. The food service manager will train dishwashing staff to monitor dish machine temperatures throughout the dishwashing process. 3. Staff will be trained to record dish machine temperatures for the wash and rinse cycles at each meal. 4. The food service manager will spot check this log to assure temperatures are appropriate and staff is actually monitoring dish machine temperatures. The surveyor reviewed the MIMA Healthcare facility policy titled Use by Date/Opened on Date, number 82, effective or revised date 1/17/2019. Under Policy the following was noted: All food items that are thawed prepared or removed from their original container will have an Expiration Date or a Use by Date. Foods in original container will have an open date. Under the Guidelines section the policy revealed the following: 1. The food Service Director will ensure foods removed from original container will have use by date. 2. All kitchen Staff and Nursing will be In Serviced on Labeling Procedures. 6. Foods opened in their original containers require an open date. The surveyor reviewed the MIMA Healthcare facility policy titled General Food Preparation and Handling, number 50, effective or revised date 1/17/2019. The policy noted the following under the Procedure section: 2. Food Storage: c. Food in broken packages or swollen cans, cans with a compromised seal, or food with an abnormal appearance or odor will not be stored. The policy also revealed the following at 5. Equipment: a. All food service equipment should be cleaned, sanitized, dried, and reassembled after each use. b. Plastic-ware or dishware that has lost its glaze or is chipped or cracked must be disposed of. The surveyor reviewed the MIMA Healthcare facility policy titled General HAACP Guidelines for Food Safety, number 47, effective and revised date 1/17/2019. The policy noted the following at Procedure 10. Dishwashing: Be sure the wash and rinse temperatures are appropriate for your dish. Document temperatures regularly on a temperature log. The surveyor reviewed the Silver Healthcare Center facility policy titled Policy and Procedure: Hand Hygiene, reviewed 2-17-20. The policy noted the following per the Skill: Hand Hygiene sheet: Rub hands palm to palm, right palm over left dorsum with interlaced fingers and vice versa, palm to palm with fingers interlaced, back of fingers to opposing palms with fingers interlocked, rotational rubbing of left thumb clasped in right palm and vice versa for 20 sec. NJAC 8:39-17.2(g)
F 0814 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Dispose of garbage and refuse properly.** Based on observation, interview, and record review, it was determined that the facility failed to provide a sanitary environment for residents, staff and the public by failing to keep the garbage container area free of garbage and debris; and, failed to have a cover over the opening of 1 of 1 dumpster and 1 of 2 kitchen grease containers. This deficient practice was evidenced by the following: On 3/11/2020 from 11:12 AM to 11:47 AM, the surveyor, accompanied by the Cook Supervisor (CS), observed the following in the kitchen: 1. There were two 55 gallon drums in the designated facility garbage area; one drum was covered with a metal lid, and the other drum that contained what appeared to be used cooking oil was opened and exposed. The drum was labeled Kitchen Grease Only. The ground surrounding the drum and the trash compactor area was black and appeared to be oily/greasy. The CS stated, That oil drum shouldn't be stored like that, it will attract rodents. The grease should be stored away from here. This area needs to be cleaned up. The surveyor reviewed the MIMA Healthcare policy titled Garbage & Rubbish Disposal, number 78, effective or revised date 1/17/2019. The policy noted the following under the Guidelines section: 1. All garbage and rubbish containing food waste shall be kept in containers. 2. All containers shall be provided with tight-fitting lids or covers, and such containers must be kept covered when stored or not in continuous use. 5. Garbage and rubbish containing food waste shall be stored as to be inaccessible to vermin. 8. Outside dumpsters provided by a garbage pick up services must be kept closed and free of litter around the dumpster area. NJAC 8:39-19.3(c)
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, it was determined that the facility failed to maintain contact isolation precautions for 2 of 2 residents (Resident #24 and #172) reviewed for isolation. This deficient practice was evidenced by the following: 1. The surveyor reviewed the medical record of Resident #172 and observed an 11/26/2019 physician's orders [REDACTED].) On [DATE]20 at 1:55 PM the surveyor observed a sign on Resident #171's room door that instructed people to STOP see nurse before entering and to utilize gloves, hand hygiene, and gown as well as a 3 drawer clear plastic container outside the resident's room that held the supplies required to don proper Personal Protective Equipment (PPE). At that time, the surveyor observed a Licensed Practical Nurse (LPN) enter the isolation room without donning PPE. When interviewed at that time, the LPN acknowledged that Resident #171 was on contact isolation for [MEDICAL CONDITION]. When interviewed on 3/11/2020 at 4:59 PM, the Director of Nursing stated that if a resident is on contact precautions, her expectation is that the isolation instructions on the signs outside of resident rooms should be followed. 2. During an initial tour of the facility on 3/4/2020 at 10:11 AM, the surveyor asked the Registered Nurse/Unit Manager (RN/UM) if there were any residents on the floor who were on isolation precautions. The RN/UM stated, Resident #24 is on contact isolation for ESBL in the urine. (ESBL, Extended-spectrum beta-lactamases, is a bacterial infection.) The surveyor then asked the RN/UM what type of PPE should be donned before entering the resident's room. The RN/UM stated, Anybody who enters the room must have gown and gloves. The surveyor also observed a 3-compartment plastic storage unit outside of the resident's room and signage, noting STOP before entering the room and signage detailing contact precautions. On 3/4/2020 at 10:17 AM, the surveyor observed a female staff member enter the room of Resident #24 without gown and gloves. The staff member then exited the room carrying a meal tray. The surveyor observed the staff member place the meal tray on a multi-tiered wheeled cart in the hallway. Upon placing the meal tray on the cart, the RN/UM approached and asked the staff if she had just entered Resident #24's room without gown and gloves. The staff responded, yes. The RN/UM stated, That is an isolation room, and you need to have gown and gloves on. You need to come with me immediately to wash your hands so that you do not spread infection. Upon completion of washing her hands, the female staff member returned to the hallway to collect additional meal trays from the breakfast meal. When interviewed at that time, the staff member identified herself as a Dietary Aide (DA) and stated, I collect the trays on all the floors, but no one told me I have to wear gloves, gown, and mask when I enter the room. The nurses never told me that. The surveyor asked the DA if she had observed the signage on Resident #24's doorway before entering the room. The DA stated, The sign tells me to stop and go to the nursing station before entering the room. I'm sorry. The next time I will wear a gown and gloves. When interviewed on 3/4/2020 at 10:27 AM, the Licensed Nursing Home Administrator (LNHA), who had arrived on the hallway upon completion of the surveyor's interview with the DA, stated, She will be inserviced again. She has already been inserviced previously. She should have had a gown and gloves prior to entering the room. I am going to have my Infection Preventionist (IP) person inservice her right now. The surveyor then observed the IP inservice the DA on how to properly don gown and gloves prior to entering the isolation room. The surveyor reviewed the resident's medical record and observed a [DATE] physician's orders [REDACTED]. In addition, the surveyor observed a 2/27/2020 PO for continue contact precautions for ESBL/MRSA in the urine. NJAC 8:39-27.1(a)