

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  315280	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/21/2025
NAME OF PROVIDER OR SUPPLIER  Silver Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Based on interviews, and review of pertinent facility documents on 10/29/25, it was determined that the facility failed to provide adequate supervision for a cognitively impaired resident (Resident #2) with documented history of exit seeking behaviors; and who eloped from the facility on 10/16/2025. The deficient practice was identified for 1 of 5 residents reviewed (Resident #2). Review of facility document dated 10/16/2025 titled Incident-Elopement-Reference #2645660 revealed that on 10/16/2025 at approximately 10:20 a.m., staff went to invite the resident to join an activity program and noticed the resident was not in their room. Review of multiple staff statements revealed that staff saw Resident #2 pacing around the unit and hallways earlier in the morning prior to their elopement. According to statement from the staff member assigned to monitor the resident every 15 minutes, the last time she saw Resident #2 on the unit was at approximately 10:10 a.m. The nurse then started to search for the resident in the rooms and in the dayrooms but did not locate the resident. At that time, they initiated code gray (missing person code) and staff started to search for the resident both inside and outside of the facility building. At approximately 10:40 a.m., a staff member saw the resident who was walking in the strip mall parking lot adjacent to the facility. The resident was then assisted back inside the facility without incident. Staff completed a skin assessment on the resident which showed no skin alterations, and the resident denied pain or discomfort. The assigned Licensed Practical Nurse (LPN #1) and the assigned Certified Nursing Assistant (CNA #1) confirmed during interview that they observed Resident #2 pacing around on the unit prior to their elopement. LPN #1 stated that usually, the assigned nurse and assigned CNA monitored the resident, and if the CNA was busy doing other tasks, she would inform the nurse. LPN #1 stated that CNA #1 was busy doing care in a resident's room and did not inform her. CNA #1 confirmed that she did not inform the nurse that she was busy doing care in another resident's room; and stated she should have informed the nurse. The facility's failure to provide adequate supervision to ensure the safety of a cognitively impaired resident who was at risk for elopement, with documented history of exit seeking behaviors, posed a likelihood of serious harm, injury, impairment or death. This resulted in an Immediate Jeopardy (IJ) situation. The IJ began on 10/16/2025 at 10:03 a.m. The facility was notified on 10/21/25 at 5:08 p.m. The facility submitted a Removal Plan (RP) on 10/28/25 at 2:10 p.m. The surveyor verified the implementation of the RP onsite on 10/29/2025 at 11:00 a.m. The evidence was as follows: A review of the facility's policy with a reviewed/revised date of 10/2025, titled Wandering/Elopement Policy indicated: Policy Statement: It is the objective of this facility to ensure the safety and protection of wandering residents by preventing their exit from the building. Purpose: The facility strives to prevent resident/patient elopement. The facility will strive to identify residents at risk for unsafe wandering and exit seeking behavior and to develop individualized prevention and management interventions. Policy Interpretation and Implementation. 2.) develop individualized interventions in the care plan to address the potential for elopement. Interventions may include but not limited to the following. Protected list of names and photographs of those at risk for elopement. Regular rounds. Staff interventions. Structured group activities. Procedure 1.) Assess the security of potential internal environmental risk factors including Elevators, Exit doors. The Facility Reportable Event record (FRE) dated 10/17/2025, which the facility submitted to the New Jersey Department of Health (NJDOH), revealed on 10/16/2025, at approximately 10:30 a.m., an employee noticed that Resident #2 was not in their room. The employee inquired of the resident's whereabouts at the nurse's station and when the resident could not be located, a code gray (missing person) was initiated. Staff searched the unit(s) and premises and Resident #2 was located in the adjacent strip mall's parking lot across from the facility. The resident was assisted back to the unit and assessed. No pain or injuries were noted. A facility document dated 10/16/2025 titled Incident-Elopement-Reference #2645660 included that on 10/16/2025, Resident #2 was monitored on every 15 minutes watch schedule (Q15 minute monitoring) and that staff last saw Resident #2 in their room pacing at 10:00 a.m. The Incident Report stated that around 10:13 a.m., staff went to offer coffee to the resident but did not see the resident in their room. The staff member then informed the nurse who then looked for the resident in the room and dayroom but did not locate them. At that time a code gray was initiated. A search began for Resident #2 in all rooms and the entire facility premises in accordance with facility protocol. Staff located Resident #2 at approximately 10:40 a.m. walking in a strip mall parking lot adjacent to the facility. The resident was then assisted back inside the facility without incident. Staff also completed a skin assessment which showed no skin alterations. The resident denied pain or discomfort and both physician</p>		