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 02/04/2026
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)
F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Complaint #: 2734069 Based on interviews, record reviews, and review of facility documents, it was determined that the facility failed to provide adequate monitoring and supervision to prevent a fall that caused a skin tear, facial bruising, and admission to the hospital for subdural hematoma (collection of blood in the tissues of the body outside of the blood vessels) to a resident who was assessed as a high risk for falls, had two previous falls in the facility, and was on one-to-one monitoring. This deficient practice occurred for 1 of 4 residents (Resident #2) reviewed for accidents. This deficient practice was evidenced by the following:Resident #2 no longer resided at the facility. A closed record review was conducted. A review of the admission Record revealed that Resident #2 was admitted to the facility with diagnoses including but not limited to: multiple fractures of ribs, left side, subsequent encounter for fracture with routine healing; laceration without foreign body of other part of the head, subsequent encounter; unspecified fall, subsequent encounter; muscle weakness; other lack of coordination; and unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool dated 12/04/2025, revealed that Resident #2 had a Brief Interview for Mental Status (BIMS) score of 12 out of 15, indicating that the resident had moderate cognitive impairment. The MDS revealed that Resident #2 used a wheelchair while at the facility, had impaired range of motion to their upper extremities and was dependent on a helper to move from sitting to standing. The MDS further revealed that Resident #2 had fractures related to a fall in the 6 months prior to admission. A review of Fall Risk Evaluations (FREs), Progress Notes (PNs) and the Care Plan (CP) for Resident #2 revealed the following: On 11/28/2025 the resident received a FRE score of 18, which indicated that the resident was at risk for falls. Resident #2's CP revealed a focus which indicated that the resident was at risk for falls related to confusion, gait/balance problems, and a history of falls. The initiation date was 12/01/2025. Interventions included but were not limited to anticipate the resident's needs, place the call bell within reach, and wear appropriate footwear. A PN dated 12/11/2025 at 11:24 PM, revealed that resident #2 had an unwitnessed fall, the resident stated to staff that they bumped their head and fell. Physician #1 was notified and ordered that Resident #2 go to the hospital. The resident was sent to the hospital via 911. On 12/11/2025, after the fall, Resident #2 received a FRE score of 9, which indicated that the resident was at low risk for falls. A review of Resident #2's CP revealed a focus of, Resident #2 is at risk for falls related to confusion, gait/balance problems, history of falls, with interventions including but not limited to: every two-hour toileting at night, and use of non-skid socks being initiated on 12/11/2025. A PN dated 12/12/2025 at 4:36 PM, revealed that Resident #2 had an unwitnessed fall in the bathroom. The resident had hematoma (collection of blood in the tissues of the body outside of the blood vessels) and laceration (cut or tear) to the back of their head with active bleeding. The physician was notified, and Resident #2 was sent to the hospital. On 12/12/2025 (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315280	A. Building B. Wing	02/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Resident #2 received a FRE score of 17, which indicated that the resident was at high risk for falls. A review of Resident #2's CP revealed a focus of, Resident #2 is at risk for falls related to confusion, gait/balance problems, history of falls, with interventions including but not limited to: one-to-one supervision being initiated on 12/12/25. A PN dated 12/29/2025 at 11:28 PM, revealed that Resident #2 had an unwitnessed fall across from the nurse's station at 11:10 PM. The PN revealed that the resident's one-to-one monitor had left. The PN further revealed that Resident #2 sustained a skin tear to their left upper arm. A PN written by Nurse Practitioner #1, dated 12/30/2025 at 11:50 AM was reviewed. The PN revealed that Resident #2 had a bruise on their forehead and a skin tear on their arm. The PN revealed that Resident #2 had new-onset aphasia (difficulty speaking or understanding what others say) and was unable to identify items which they were previously able to name. The PN further revealed that because of the neurologic change after the fall Resident #2 was to be sent to the Emergency Department via 911 for a CT scan of the brain. A PN dated 12/31/2025 at 1:02 AM, revealed that Resident #2 was admitted to the hospital for subdural hematoma. An Incident Report (IR) dated 12/29/2025 at 11:10 PM, written by Registered Nurse (RN) #1 was reviewed. The IR revealed that Resident #2 and a staff member indicated that the resident had fallen at the nurse's station. The staff member denied witnessing the fall. A handwritten statement by RN #1 dated 01/01/2026 revealed that on 12/29/2025 Resident #2 fell and injured their arm. The statement revealed that during the 3:00 PM - 11:00 PM, shift Resident #2 had one-to-one monitoring, but RN #1 was unsure when the one-to-one and Resident #2 separated. RN #1's statement revealed that Resident #2 was observed speaking to Licensed Practical Nurse (LPN) #1 prior to their fall, but RN #1 did not know if Resident #2 was placed in the care of LPN #1 when CNA #1 (who had been the resident's one-to-one monitor for the 3:00 PM- 11:00PM shift) left the unit and before her replacement arrived. The statement further revealed that at approximately 11:10 PM, Resident #2 was found on the floor asking for help. A handwritten statement by Certified Nursing Assistant (CNA) #1, dated 01/02/2026, was reviewed. The statement revealed that CNA #1 asked LPN #1 to watch Resident #2 and left the unit at the end of her shift. The statement further revealed that LPN #1 then asked another CNA (CNA #2) to watch Resident #2. An emailed statement from LPN #1 dated 01/02/2026 at 12:13PM, was reviewed. The statement from LPN #1 revealed that he arrived at work at 10:50 PM and saw CNA #1 with Resident #2 at the nurse's station. LPN #1 did his rounds and then returned to the nurse's station where he saw Resident #2, but not CNA #1. The statement further revealed that no one spoke with LPN #1 about Resident #2's care and he did not witness the resident's fall. A telephone statement from CNA #2 dated 12/30/2025, was reviewed. The statement revealed that the CNA clocked in to work at 11:02 PM, and observed Resident #2 sitting in their wheelchair across from the nurse's station. CNA #2 then observed Resident #2 stand up and walk. The resident's wheelchair spun, and Resident #2 hit their face and arm on the wheelchair before the CNA could reach the resident. CNA #2' s statement did not reveal that she was assigned as Resident #2's one-to-one monitor or that she had accepted responsibility for supervising the resident. An interview was conducted with the Unit Manager (UM) on 02/04/2026 at 1:03PM. The UM stated that a resident under one-to-one supervision should always have a staff member with them. The UM stated that if the staff assigned as a one-to-one needed to take a break or leave the resident another staff member must relieve them. A telephone interview was conducted with CNA #1 on 02/04/2026 at 2:02 PM. CNA #1 stated that when assigned as a one-to-one monitor, staff were supposed to remain with the resident all the time unless they were relieved by another staff member. CNA #1 stated that she was assigned as Resident #2's one-to-one monitor for the 3:00PM - 11:00PM shift on 12/29/2025. CNA #1 stated that before leaving the unit, she informed LPN #1 that Resident #2 needed one-to-one monitoring. CNA #1 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315280	A. Building B. Wing	02/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	stated that LPN #1 asked another CNA to watch Resident #2. CNA #1 could not identify the CNA that LPN #1 asked to supervise Resident #2. The Surveyor attempted to reach LPN #1 and CNA #2 for interviews but was not successful. An interview was conducted with the Director of Nursing (DON) on 02/04/2026 at 2:31PM. The DON stated that Resident #2 was on one-to-one supervision in an effort to prevent accidents. The DON stated prior to leaving Resident #2 at the nurse's station, CNA #1 told LPN #1 to supervise the resident. LPN #1's statement which denied assuming responsibility to supervise Resident #2 was reviewed with the DON. The DON offered no explanation of why LPN #1 denied witnessing Resident #2's fall or assuming responsibility for the resident's one-to-one monitoring. The DON stated that the facility's assignment sheets did not reveal which staff member was assigned as Resident #2's one-to-one monitor for the 11:00PM-7:00AM, shift on 12/29/2025. The facility policy, Continuous 1:1 Supervision with a reviewed/revised date of 01/2025 was reviewed. Under Policy, the document revealed that residents may require a temporary period of enhanced supervision to maintain their safety and the designated 1:1 monitor should be within eyesight of the resident at all times. Under Procedure, the policy revealed that the nurse in charge of each shift was responsible for assigning a staff member as the one-to-one supervisor. This section of the policy further revealed b. The staff allocated to supervise the resident/patient will not discontinue the supervision until the next staff confirms he/she has taken responsibility for supervising the resident/patient. NJAC 8:39-27.1 (a)