

State of New Jersey

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Governor
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Lt. Governor

PHILIP D. MURPHY

JUDITH M. PERSICHILLI, RN, BSN, MA Commissioner

In Re Licensure Violation:

Silver Healthcare Center

(NJ Facility ID# NJ 60407)

ADMISSIONS ORDER

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TO: Yeshaya D. Fink, Administrator Silver Healthcare Center 1417 Brace Road Cherry Hill, New Jersey 08034

Dear Mr. Fink:

As you were notified verbally yesterday, effective upon the facility's verbal notification, the Department of Health (hereinafter, "the Department") ordered the curtailment of new admissions to Silver Healthcare Center (hereinafter "Silver"). This enforcement action was taken in accordance with the provisions set forth at N.J.A.C. 8:43E-2.4 (Plan of Correction), 3.1 (Enforcement Remedies Available) and 3.6 (Curtailment of Admissions) in response to serious deficiencies observed by Department staff in Silver during its on-site inspection.

The Health Care Facilities Planning Act (N.J.S.A. 26:2H-1 et seq.) (the Act) provides a statutory scheme designed to ensure that all health care facilities are of the highest quality. Pursuant to the Act and N.J.A.C. 8:43E-1.1 et seq., General Licensure Procedures and Standards Applicable to All Licensed Facilities, the Department's Commissioner is authorized to inspect all health care facilities and to enforce the Standards for Licensure of Long-Term Care Facilities set forth at N.J.A.C. 8:39-1.1 et seq.

LICENSURE VIOLATIONS:

Staff from the Department's Health Facility, Survey and Field Operations (HFS&FO) unit were on-site at Silver on October 8, 2021. The surveyors identified egregious, deficient practices that posed an

immediate and serious risk of harm to the residents of Silver. These violations pertain to the care of residents using the services at Silver. During the tour of the Court 2 Unit, the surveyors identified the following:

- 1. The surveyor observed the hallway floors in front of the nurse's station and on the A and B hallways were sticky, dirty with brown dried substance that the staff identified as feces. It appears that someone walked in the feces and tracked it through the unit. There were pieces of trash, needle covers, tissues and cups on the floors throughout the halls.
- 2. The resident bathroom that was located on the B hallway had dried feces on the toilet and cups and trash were on the floor.
- 3. In room 218 the floor was wet with black mud and debris and tissues were on the floor. The resident was confused and lying in bed and was not able to be interviewed.
- 4. In room 216 there were black skid marks and scuffs over the entire floor and under the beds. There were smears of feces all over the floors and walls and some rash located on the floors. The mattress on the bed was faded, ripped with foam coming out the side. The trim on the wall behind the bed was broken and coming off the walls. Dried feces smears on the walls.
- 5. In room 211 and 223, the air conditioning unit covers were missing, and the inside of the air conditioning units were exposed and were full of dust and debris.
- 6. In room 221 there was a large brown spill with dried drips running down the wall and the floor was covered in brown dried debris, food particles and red stains.
- 7. In room 220 there were deep gouges in the walls and floors were dirty.
- 8. In room 224 the walls had deep gouges. Some gouges were spackled but unpainted.
- 9. In room 243 the walls had deep gouges and wallpaper was torn in multiple areas.
- 10. In room 232A, the siderail at the top of the resident's bed on the left side near the top of the bed was loose and twisted.
- 11. In room 234 the floor was dirty, discolored with scuff marks, smears of feces on the floor in multiple area and there were brown feces smears on the wall near the door.
- 12. The furniture in residents' rooms such as beds, cabinets were worn, broken, chipped, and rusted on the bedframes.
- 13. The wallpaper located in front of the nurse's station and throughout the A and B hallways were torn and peeling off the walls.
- 14. The resident's wheelchair in room 219A was dirty, dusty with a torn seat cushion and torn arm rest with foam coming out from the tears.

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- 15. Rooms 230 and 234 had broken blinds and bed sheets were being utilized as curtains.
- 16. The privacy curtains in most rooms were stained, dirty and unclean.

These are representative findings and do not necessarily include all survey findings, which will be detailed in the survey report.

CURTAILMENT:

The Department hereby orders the curtailment of new admissions to Silver effective yesterday upon verbal notification of the facility.

N.J.A.C. § 8:43E-3.4(a)(2) provides for a penalty for each resident admitted in violation of this curtailment order.

FORMAL HEARING:

Silver is entitled to contest the curtailment by requesting a formal hearing at the Office of Administrative Law (OAL). Silver may request a hearing to challenge either the factual survey findings or the curtailment, or both. Silver must advise this Department within 30 days of the date of this letter if it requests an OAL hearing regarding the curtailment.

Please forward your OAL hearing request to:

Attention: OAL Hearing Requests
Office of Legal and Regulatory Compliance, New Jersey Department of Health
P.O. Box 360
Trenton, New Jersey 08625-0360

Corporations are not permitted to represent themselves in OAL proceedings. Therefore, if Silver is owned by a corporation, representation by counsel is required. In the event of an OAL hearing regarding the curtailment, Silver is further required to submit a written response to each and every charge as specified in this notice, which shall accompany its written request for a hearing.

Due to the emergent situation and the immediate and serious risk of harm posed to the residents, the Department will not hold the curtailment in abeyance during any appeal of the curtailment.

Failure to submit a written request for a hearing within 30 days from the date of this notice will render this a final agency decision. The final agency order shall thereafter have the same effect as a judgment of the court. The Department also reserves the right to pursue all other remedies available by law.

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Thank you for your attention to this important matter and for your anticipated cooperation. Should you have any questions concerning this order, please contact Lisa King, Office of Program Compliance, at (609) 376-7751.

Sincerely,

Gene Rosenblum, Director

Division of Certificate of Need and Licensing

Office of Program Compliance

GR:JLM:sj

c. Yeshaya D. Fink, Administrator (sfink@silverhccenter.com)
Mark Pyramid, Director of Operations (mark@pyramidhcm.com)

DATE: October 15, 2021
FACSIMILE (856) 295-8922
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