STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315263	A. BUILDING ______ B. WING ______	07/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALACE REHABILITATION AND CARE CENTER, THE	**315 WEST MILL ROAD** **MAPLE SHADE, NJ 08052**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS STANDARD SURVEY 7/25/2019 CENSUS: 150 SAMPLE SIZE: 40	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to provide acceptable standards of clinical practice with transcription of Physician's Orders, following Physician's orders, and/or following manufacturer's specifications for medication administration. This deficient practice was identified for 4 of 40 residents reviewed (Residents #21, #38, #140 and #103), 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	F 658	F658 Element One - Corrective Action The MAR of Resident #103was immediately corrected and the physician notified. There was no negative effect to Resident #103. The nurse that filed to properly recap the medication was re-educated on 7/24/19 The MAR of Resident #38 was immediately corrected to note mixing medications according to manufacturer's recommendations and the physician notified. There was no negative effect to Resident #38. The nurse that failed to properly prepare the medication was re-educated on 8/7/19 Resident #140 was educated about the importance of [redacted] [redacted]. There was no negative effect to Resident #140. The nurse that	8/16/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 08/13/2019

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.

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F 658	Continued From page 1 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 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 #103 and observed that the resident had Physician's Orders for several medications that included [redacted]. The resident had been receiving the [redacted] [redacted] three times daily. On 6/18/19, the resident had been seen by the Nurse Practitioner from the [redacted] consultant group who recommended that the [redacted] be increased to [redacted] three times daily (TID). The recommendation was then approved by the resident's primary Physician and a telephone verbal order was given by the attending Physician's Advance Practice Nurse (APN) to the facility Nurse who wrote the order "Increase [redacted] TID" (three times daily) on a "Physician's Orders" sheet. This order change was then placed on the resident's June 2019 Medication Administration Record (MAR). During further review of the medical record, the surveyor observed the July 2019 that had been signed by the APN on "7/11." The APN's signature on the "Physician's Order Form" (POF) indicated that all medications on the POF had been	F 658	failed to properly instruct Resident to [redacted] [redacted] was re-educated on 7/22/19 Resident #21 was educated about the importance of [redacted] [redacted]. There was no negative effect to Resident #21. The nurse that failed to properly instruct Resident to [redacted] [redacted] was re-educated on 7/22/19 Element Two All residents have the potential of being affected by this practice. Element Three The ADON conducted a mandatory in-service for nurses regarding the proper process for recapping medications monthly and the proper administration of medications according to physician orders and manufacturer recommendations. A medication administration observation is conducted for each nurse a minimum of annually to assure they properly administer medications in compliance with physician orders and manufacturer recommendations. Element Four The consultant pharmacist and Assistant Director of Nursing will perform medication administration observations of 4 nurses a month to ensure that medications are administered according to manufacturer's specifications. Deviations will be immediately corrected	

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F 658	Continued From page 2 approved for administration. The July POF included the [redacted] but it noted the order as [redacted] TID, the old order, rather than the most recent order of [redacted] TID. The July POF had been reviewed by a Licensed Practical Nurse (LPN) for accuracy on 6/29/19. The LPN had not made the correction on the POF to reflect that the [redacted] order had been increased. When interviewed on 7/23/19 at 12:07 PM, the Unit Manager said the LPN reviewing the July POF should have made the correction. On 7/23/19 at 12:22 PM, the surveyor observed Resident #103 lying on the bed in the resident's room. The surveyor asked the resident about his/her medications and the resident was able to name all of the medications. The resident knew the [redacted] had been increased and said he/she was feeling better with the increase of the [redacted] 2. On 7/21/19 at 8:50 AM, the surveyor observed LPN#1 administering medications to Resident #38. LPN#1 gave [redacted] 1 tablet, and [redacted] 1 capsule. The surveyor observed LPN#1 crush all the medications (she opened the [redacted] and gave them to Resident #38 with chocolate pudding. Resident #38 had diagnoses that included [redacted] The resident was on aspiration precautions and supervision with meals. The current Physician's order for Resident #38 noted, "May crush medications where manufacturer permits" for all of the resident's medications. Resident #38's care plan noted "Crush medications. Mix medications with pudding before giving."	F 658	and reported to the Director of Nursing. The Director of Nursing will in-service nurses as to any deviations to ensure compliance with manufactures instructions. The DON will review the results of the monthly observations by the pharmacy consultant and the Assistant Director of Nursing and report the findings quarterly for three months to the QA Committee and Administrator for action as appropriate. Following the three-month period, the QA committee will recommend continuation of audits based on findings. 20% of monthly recaps are checked by each unit manager to assure new orders are correctly transcribed onto new POS. The unit managers will report findings monthly to the DON for action as appropriate. The DON will report aggregate findings at the quarterly QA committee for action as appropriate.	

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F 658	Continued From page 3	F 658		

The surveyor reviewed the manufacturer's specifications for [redacted] administration which noted, "Administer [redacted] orally with or without food. [redacted] capsules should be swallowed whole with water. The surveyor reviewed the manufacturer's specifications for [redacted] administration which noted, [redacted] may be crushed and administered and suspended in water, 5% dextrose in water (D5W) or apple juice or mixed with applesauce and promptly administered orally. Crushed [redacted] tablets are stable in water, D5W, apple juice and applesauce for up to 4 hours."

On 7/24/19 at 9:44 AM the surveyor interviewed LPN#1 regarding the crushed medications for Resident #38. LPN#1 said she wasn't aware of the Physician's order regarding crushed medications for the resident or the manufacturer's instructions for the medications given. LPN #1 stated, "It was like that when I came here" and, "I wasn't aware of that." LPN#1 stated the resident would not take the medications if they were not given in vanilla or chocolate pudding. In an interview with LPN#1 on 7/24/19 at 1:30 PM, the LPN stated "I crushed the medications, then opened the capsule over the pudding and mixed them all together."

3. On 7/21/19 at 9:15 AM, the surveyor observed LPN#1 administer medications to Resident #140. Resident #140 received an [redacted]
The surveyor reviewed the manufacturer's specifications which noted, "After each dose, [redacted]."
LPN#1 did not ask the resident to [redacted]

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F 658	Continued From page 4	F 658		

after the administration of the The surveyor also observed that the MAR included,

On 7/24/19 at 10:15 AM, the surveyor interviewed the LPN regarding the administration of the to Resident #140. The LPN stated when she administered the , she asked Resident #140 if he/she wanted to The surveyor informed the LPN that she had not asked Resident #140 during the medication observation and she stated, "Oh sorry." The LPN stated the resident always refused, so that's probably why she didn't ask Resident #140 if he/she wanted to that day.

On 7/24/19 at 12:05 PM, the surveyor interviewed the resident about rinsing his/her mouth after administration of the . Resident #140 stated the LPN doesn't ask him/her to

4. On 7/21/19 at 8:52 AM, the surveyor observed a LPN #2 administer medications to Resident #21. The LPN administered , to the resident without offering the resident anything to .

On 7/22/19 at 8:54 AM, the surveyor interviewed LPN #2 regarding the process for administering . The LPN stated she usually offers the resident with after administering an , however, she did not offer Resident #21 a during the medication pass on 7/21/19.

A review of the resident's Physician's Order Form revealed an order for dated 1/17/19 which

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F 658	Continued From page 5 included, [redacted] after use to decrease [redacted] NJAC 8:39-11.2(b)	F 658		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on medication pass observation, interview, medical record review, it was determined that the facility failed to administer medications with less than a 5% medication error rate. The surveyor observed 2 of 2 nurses with the opportunity to administer 44 doses of medication to 5 residents. There were three errors observed for 2 of 5 residents, residents #38 and #21, resulting in a 6.82% medication error rate. This deficient practice was evidenced by the following: 1. On 7/21/19 at 8:50 AM, the surveyor observed the Licensed Practical Nurse (LPN) #1 administer medications. LPN#1 gave [redacted] 1 tablet and [redacted] 1 capsule. The surveyor observed LPN#1 crush the [redacted], and then mix the medications into chocolate pudding which she then gave to Resident #38.	F 759	F759 Element One - Corrective Action The MAR of Resident #38 was immediately corrected to note mixing medications according manufacturer's recommendations and the physician notified. There was no negative effect to Resident #38. The nurse that failed to properly prepare the medication was disciplined and re-educated on 8/7/19 The nurse was disciplined and re educated on 7/22/19 regarding following physicians orders to ensure administration of proper dose. The physician was notified with no new orders. There were no negative effects to resident #21. Element Two All residents have the potential of being affected by this practice. Element Three The ADON conducted a mandatory	8/16/19

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F 759	Continued From page 6	F 759		

The surveyor reviewed the manufacturer's specifications for [REDACTED] administration which noted that [REDACTED] capsules should be swallowed whole with water. The surveyor reviewed the manufacturer's specifications for [REDACTED] administration which noted, [REDACTED] may be crushed and administered and suspended in water, 5% dextrose in water (D5W) or apple juice or mixed with applesauce and promptly administered orally. Crushed [REDACTED] tablets are stable in water, D5W, apple juice and applesauce for up to 4 hours."

On 7/24/19 at 9:44 AM the surveyor interviewed LPN#1 regarding the crushed medications for Resident #38. LPN#1 said she wasn't aware of the manufacturer's specifications for the two medications given and stated, "It was like that when I came here," and "I wasn't aware of that." LPN#1 stated the resident would not take the medications if they were not given in vanilla or chocolate pudding. In an interview with LPN#1 on 7/24/19 at 1:30 PM, the LPN stated, "I crushed the medications, then opened the capsule over the pudding and mixed them all together." (Errors #1 and #2)

2. On 7/21/19 at 8:52 AM, the surveyor observed LPN #2 administer two puffs of [REDACTED], to Resident #21.

The surveyor reviewed Resident #21's Physician Order Form (POF) which revealed an order, [REDACTED]" dated 1/17/19.

On 7/22/19 at 8:54 AM, the surveyor interviewed

Provider's Plan of Correction (F 759):

in-service for nurses regarding the proper administration of medications according to physician orders and manufacturer recommendations including the "5 Rights" of medication administration.

A medication administration observation is conducted for each nurse a minimum of annually to assure they properly administer medications in compliance with physician orders and manufacturer recommendations.

Element Four
Medication administration observations will be conducted on all new nursing staff within two weeks of hire and all licensed nurses will have a medication competency observation on their anniversary date of hire by the pharmacy consultant or ADON. These observations will include the nurses adherence to the manufacturers specifications for medication administration. Any deviations will be reported to the DON for further corrective action.

The DON will review the results of the monthly observations by the pharmacy consultant or ADON and report the findings quarterly for three months to the QA Committee and Administrator for action as appropriate. Following the three-month period, the QA committee will recommend continuation of audits based on findings.

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F 759	Continued From page 7 LPN #2 regarding the administration of [redacted] to Resident #21. When asked how many [redacted] of [redacted] the LPN administered, she stated, "I think I gave two." The LPN then checked the Medication Administration Record and verified that the resident should have only received one [redacted] (Error #3) NJAC 8:39 - 29.2(d)	F 759		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced	F 761		8/16/19

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F 761	Continued From page 8 by: Based observation, interview and record review, it was determined that the facility failed to maintain accurate documentation and temperature levels for the medication refrigerator on 1 of 3 nursing units ██-Wing). This deficient practice was evidenced by the following: On 7/21/19 at 10:15 AM, the surveyor observed a medication storage room on the █ wing nursing unit. The temperature for the medication refrigerator had an internal temperature of 30 degrees. A sign on the outside of the medication refrigerator door read, "Refrigerator temps must be between 36 and 46. Please be sure to check and record temps daily." The surveyor reviewed the temperature log dated July 2019 and observed the temperatures had not been recorded for 8 days. When interviewed at that time, the Unit Manager (UM) stated the 11-7 shift was responsible for the refrigerator temperatures. The surveyor asked the UM if the temperatures were done for the previous 11-7 shift. The UM responded, "It didn't seem like they did it." The UM filled out the temperature for 7/21/19 in front of the surveyor. The surveyor reviewed the temperature log for June 2019, and observed that three days of the month were not completed. The UM stated she thought the June 2019 temperature log was completed when she last saw it. At that same time, accompanied by the UM, the surveyor inquired about the procedure for temperatures below the range indicated. The UM responded that they would alert maintenance and then call	F 761	F761 Element One - Corrective Action The thermometer was replaced in the medication refrigerator on the █ Wing unit on 7/21/19 during the survey. Maintenance also checked the refrigerator to assure it was properly functioning. Medication in the refrigerator was discarded as a precaution. The nurses who failed to properly complete the refrigerator temperature log were counseled and re-educated. The unit manager will check the log daily to assure the temperatures are properly recorded and within the correct range. Element Two All residents have the potential of being affected by this practice Element Three The ADON conducted a mandatory in-service for nurses regarding checking medication refrigerator temperatures and completing the temperature log. The education also included monitoring to assure temperatures remain within the proper range. Element Four The ADON/designee will conduct random observations of the medication refrigerators weekly for three months to ensure that the temperatures are within the desired range and the temperature logs are properly completed in compliance with facility policy. Any deviations will be	

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F 761	Continued From page 9 the pharmacy to see if the medications in the refrigerator were still good. The UM discarded the medications which had not been administered to residents. On 7/22/19 at 9:00 AM, the surveyor interviewed the UM about the temperatures in the medication refrigerator. The UM stated she thought the thermometer was broken. The surveyor asked the UM how long the thermometer was broken. The UM stated, "I'm not sure. There have not been temperatures done since July 13, 2019." When interviewed on 7/25/19 at 10:19 AM, the DON stated the night shift (11 PM-7 AM) was responsible for recording the temperatures for the refrigerator. When interviewed further, the DON stated the UM was responsible for checking the log to make sure it was completed. NJAC 8:39-11.2(b) 27.1(a)	F 761	reported to the DON for further corrective action. The DON will review the results of the weekly observations by the ADON/designee and report the findings quarterly for three months to the QA Committee and Administrator for action as appropriate. Following the three-month period, the QA committee will recommend continuation of audits based on findings.	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.	F 812		8/16/19

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F 812

Continued From page 10

(iii) This provision does not preclude residents from consuming foods not procured by the facility.

§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, it was determined that the facility failed to handle potentially hazardous food and 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 7/21/19 from 8:43 AM to 9:40 AM, the surveyor, accompanied by the dietary Supervisor, observed the following in the kitchen:

1. The surveyor observed the "Daily Freezer/Refrigerator Temperature Log" that was attached to the walk-in freezer door. The surveyor observed that the temperature log was not completed on the following dates: 7/19/19 during the PM and 7/20/19 during the PM shift.
According to the "Instructions" on the top of the temperature log, "A designated food service employee will record the time, air temperature and their initials (preferably upon arrival) once in the morning and once (preferably just before leaving the facility) in the afternoon."

2. In the dry storage area on a middle shelf, a can of kidney beans had a substantial dent on the side seam of the can. The Supervisor stated, "I don't know why that is up here, we don't use damaged cans. Yeah, I'm gonna get rid of it." On

F 812

F812
Element One
*The temperature log was corrected and the staff that failed to follow the correct procedure for documenting temperatures were re-educated.
*The can of kidney beans was discarded.
*The bag of pasta not properly labeled or stored was discarded.
*The undated food in the walk in refrigerator was immediately discarded.

*The dish machine temperature and sanitizing log was redone to reflect the correct procedure. The staff member who completed the log incorrectly was re educated.
*The box of gloves was removed from the top of the dishwasher.
*The top of the dishwasher was cleaned of all debris.
*The desert plates were rewashed and properly stored per facility procedure.
*The single serve portions of condiments and other items found in the upper drawer of the C wing pantry were discarded and the drawer properly cleaned.
*The jar of honey in the walk in refrigerator was discarded.

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	315263	A. BUILDING ______ B. WING ______	07/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PALACE REHABILITATION AND CARE CENTER, THE	**315 WEST MILL ROAD MAPLE SHADE, NJ 08052**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 812 Continued From page 11

a middle shelf an opened package of pasta noodles was wrapped in clear plastic wrap. The package of pasta noodles had no dates. The Supervisor said, "That should be labeled with an open and use by date." The Supervisor removed to trash.

3. On a middle shelf in the walk-in refrigerator, a half pan contained what appeared to be grape jelly covered with plastic wrap. The pan had no date. The Supervisor stated, "I think we just opened that yesterday." On an upper shelf, a half pan covered with plastic wrap contained what appeared to be a roast turkey. The Supervisor stated, "That's a turkey for tonight, we cooked it yesterday. It should have been labeled."

4. The low temperature dish machine was being used by staff. The surveyor and Supervisor reviewed the "Dish Machine Temperatures & Sanitizing Log", dated 7-2019. Review of the log revealed that the log was completed for all meals on 7/21/2019 (AM, Noon and PM) at 9:12 AM. The supervisor stated, "That should be filled out before they start washing each time." When interviewed on 7/24/19 at 11:26 AM, the Food Service Director (FSD) stated, "That log should only be filled out prior to breakfast service, lunch service and dinner service. That log should not have been filled out for the whole day. She is a new employee and I corrected her."

5. The surveyor observed the top of the low temperature dish machine and noted that the top of the machine was covered with unidentified food debris. The surveyor also observed a box of disposable gloves on top of the dish machine that

F 812

Dietary staff received re-education regarding proper storage and dating & labeling of food, and kitchen sanitation.

All areas where refrigerated foods and dry foods were stored were checked to ensure that they were dated and properly stored once opened.

Prepared foods were inspected to ensure that they were covered, labeled and dated. The refrigerator and freezer were inspected to ensure that there were no other food items that were undated.

The pantry drawer on █ wing has been permanently locked and will not be accessible to residents or staff.

Element Two
All residents have the potential to be affected by these practices

Element Three
The food service director provided re-education to dietary staff regarding the facility sanitation and food storage and labeling procedures.

The Regional Administrator conducts random kitchen inspections with the FSD monthly to assure compliance with kitchen sanitation and food storage regulations. Inspection findings will be discussed with the Administrator monthly for action as appropriate.

Element Four
The FSD will conduct random

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F 812

Continued From page 12

was resting on the unidentified food debris. The surveyor interviewed the FSD on 7/24/19 at 12:19 PM who stated, "The dish machine should be cleaned after each service by the person assigned to dishwashing duty. The gloves do not belong on top of the machine."

On 7/23/19 from 10:43 AM to 11:03 AM, the surveyor, accompanied by the FSD, observed the following in the kitchen:

6. The surveyor observed a storage/dry storing rack in the cooks area. The surveyor observed 4 stacks of cleaned and sanitized dessert plates on a top shelf and 2 stacks of cleaned and sanitized dessert plates on a middle shelf, that are used to serve resident meals. On interview, the FSD stated, "Those were just cleaned. They should be in a plastic container and sealed with a cover."

On 7/24/19 from 9:25 AM to 9:38 AM, the surveyor, accompanied by the Director of Nursing, observed the following on the █-Wing Unit Pantry:

7. An upper drawer below the counter and closest to the wall contained various single serve portion packages of condiments (jellies, butter, duck sauce, ketchup) that had no dates and were exposed to room temperature. The surveyor also noted what appeared to be a broken fan, a pair of scissors and a D size Energizer battery in the drawer with the condiments. The DON stated, "The housekeeping department I believe is in charge of maintenance of the pantry." The DON on observation of the condiment drawer stated, "That is unacceptable. I'm going to have that taken care of right away."

F 812

observations of the temperature logs weekly for 3 months to ensure that the temperatures are within the desired range and the temperature logs are properly completed in compliance with facility policy. Any deviations will be reported to the administrator and QA committee quarterly on an ongoing basis for further action as needed.

The FSD conducts weekly inspections of the kitchen to assure compliance with all sanitation, food storage, labeling and dating, and food handling and preparation regulations. The FSD will provide a copy of the weekly inspections to the Regional Administrator monthly on an ongoing basis for review and action as needed. Any deviations will be reported to the Administrator and QA committee quarterly on an ongoing basis for further action as needed.

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F 812	Continued From page 13	F 812		

On 7/24/19 from 11:28 AM to 11:42 AM, the surveyor, accompanied by the FSD, observed the following in the kitchen:

8. On a rear middle shelf in the walk-in refrigerator, an opened container of honey was dated "opened" 5/19 and had a "use by date" of 6/19. The FSD stated, "That will be discarded."

The surveyor reviewed the "Cleaning Assignments" sheet, undated and provided by the FSD. Under the heading "Daily" cleaning assignments, the sheet listed "clean dish machine"

The surveyor reviewed The Palace Rehab and Care Center Dietary Policy and Procedures titled "Labeling and Dating Food Items and Shelf Life", undated. Under "Procedure" the policy stated at 1. "Food items, as appropriate will be labeled and dated by dietary staff using the following labeling system: Received Date A.) "Will be placed on food items when received by the dietary department from vendor and B.) "If removed from the original box, individual packages within the box will be dated with the received date." In addition, under the "Dry Goods Dating" section, at 2. the policy stated, "Perishable foods and dated products are checked daily for spoilage and expiration by the FSD."

The surveyor reviewed the "Dish Washing Procedure", undated. The procedure stated "The temperature of the dish machine must be taken prior to washing dishes."

The surveyor reviewed the "Dented Can Procedure", undated. The procedure stated "When dented cans are found when an order

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F 812	Continued From page 14 comes in, it is moved to the dented can area downstairs in the pantry room. We then return the dented cans to the vendor we received them from." NJAC 8:39-17.2(g)	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other	F 880		8/16/19

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F 880	Continued From page 15 persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to follow appropriate hand hygiene practices. This	F 880	F880 Element One - Corrective Action The nurse who administered medications	

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F 880	Continued From page 16 deficient practice was observed for 1 of 2 nurses who administered medications to 2 of 5 residents during the medication pass (Resident #21 and Resident #400). This deficient practice was evidenced by the following: On 7/21/19 at 8:52 AM, the surveyor observed a Licensed Practical Nurse (LPN) administer medications to Resident #21. Afterwards, the LPN washed her hands for nine seconds. She then rinsed her hands with water, re-applied soap, and washed her hands for another six seconds. On 7/21/19 at 9:05 AM, the surveyor observed the same LPN administer medications to Resident #400. The LPN administered the resident's PO (by mouth) medications and then immediately donned gloves to administer [REDACTED] medication, into the resident's [REDACTED]. The LPN did not perform hand hygiene between administering the PO and [REDACTED] medications. After administering the [REDACTED] the LPN washed her hands for 14 seconds. On 7/21/19 at 9:28 AM, the surveyor interviewed the LPN regarding hand hygiene. The LPN stated that she tries to wash her hands for as long as she can which is usually 20 to 30 seconds. On 7/24/19 at 09:17 AM, the surveyor interviewed the LPN regarding her normal process for administering [REDACTED]. The LPN stated that she would don gloves, raise the resident's [REDACTED] administer the [REDACTED], and then give the resident a [REDACTED]. When asked if	F 880	to Resident #21 and Resident #400 was immediately counseled and re-educated regarding proper hand washing technique when administering medications. A return demonstration was completed to assure understanding. Element Two All residents have the potential of being affected by this practice Element Three The ADON conducted a mandatory in-service for nurses regarding the proper hand hygiene when administering medications to prevent the spread of infections. Element Four The pharmacy consultant and the ADON will perform medication administration observations monthly, including proper hand washing procedures annually for all licensed nurses and for new nurses within two weeks of hire. Any deviations will be reported to the DON for further corrective action. The DON will review the results of the monthly observations by the pharmacy consultant and ADON and report findings quarterly for three months to the QA Committee and Administrator for action as appropriate. Following the three-month period, the QA committee will recommend continuation audits based on findings.	

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F 880	Continued From page 17 there was anything the LPN should be doing prior to donning gloves, the LPN stated, "I should probably wash my hands." The surveyor then asked if the LPN washed her hands prior to administering [redacted] to Resident #400. The LPN replied, "I don't remember." The surveyor reviewed two facility policies. The first policy, "Handwashing" included, "Appropriate thirty (30) second handwashing must be performed under the following conditions: ...Before preparing and handling medications." The second policy, "Instillation of [redacted]" had a section titled "Steps in the Procedure" which included, "2. Wash and dry your hands thoroughly" and then "3. Put on gloves." NJAC 8:39-19.4(a)(1).	F 880		
F 919 SS=D	Resident Call System CFR(s): 483.90(g)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area. §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to ensure a call bell system's auditory alarm function was working on 1 of 3 units (A Wing). This deficient practice was evidenced by the following:	F 919	F919 Element One The call bell system functioning on the A wing was immediately checked and the administrator noticed a button was pressed causing the audible alarm to ring at a very low level. The administrator	8/16/19

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F 919	Continued From page 18 On 7/22/19 at 11:00 AM, Surveyor #1 met with 10 alert and oriented residents. When asked if the staff respond to the call bells in a timely manner, 5 of 10 residents (Resident #18, #98, #103, #129, and #402) complained that the staff took too long to answer call bells. Resident #98 further stated, that when a call bell was pressed on the A Wing, there was no auditory alarm at the nurses station. On 7/22/19 at 1:35 PM, two surveyors tested the call bell system on █ Wing in the presence of the Administrator. Surveyor #1 entered a resident's room and pressed the call bell while Surveyor #2 and the Administrator, stood at the nurses station to observe the call bell answering machine. When Surveyor #1 pressed the call bell, the light outside the resident's room and the room number on the call bell answering machine lit up, however, there was no audible alarm. When Surveyor #2 asked the Administrator why there was no alarm sounding, the Administrator replied, "I don't know." The Social Worker (SW), who was also seated at the █ Wing nurses' station, started to press buttons on the call bell machine which caused an audible alarm to sound. The SW stated that the call bell machine could not be muted but acknowledged that prior to pressing the buttons on the machine, the call bell machine was not sounding any alarm to indicate a call bell was activated. On 7/22/19 at 1:55 PM, Surveyor #1 interviewed Resident #98 in his/her room. When asked how long the resident had noticed the call bell system wasn't making an auditory alarm, the resident stated "for as long as I've been here which is about four years."	F 919	corrected the level and all nursing staff were immediately re-educated to assure the alarm is audible in the hallway as well as the nursing station. Element Two All residents have the potential to be affected. Element Three All unit call bell systems were checked and found to be functioning properly. Nursing staff on all shifts received re education on the proper use and function of the call bell system to assure the volume of the audible alarm is kept high enough so it can be heard at the nursing station and in the hallways. Element Four The Maintenance Director/designee conducts daily rounds and checks the call bell systems to assure they function, and the audible alarm is working and can be heard in the hallways as well as the nursing station. Finding of these rounds are discussed with administration at morning management meetings and reported by the Maintenance Director at the quarterly QA committee and acted upon as appropriate.	

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F 919	Continued From page 19 A review of the facility's policy titled, "Answering the Call Light" included, "report all defective call lights to the nurse supervisor promptly." NJAC 8:39-27.1(a)	F 919		

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	060307	A. BUILDING: ______ B. WING ______	07/25/2019

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S 000	Initial Comments THE FACILITY WAS NOT IN COMPLIANCE WITH THE STANDARDS IN THE NEW JERSEY ADMINISTRATIVE CODE, CHAPTER 8:39, STANDARDS FOR LICENSURE OF LONG TERM CARE FACILITIES. THE FACILITY MUST SUBMIT A PLAN OF CORRECTION, INCLUDING A COMPLETION DATE, FOR EACH DEFICIENCY AND ENSURE THAT THE PLAN IS IMPLEMENTED. FAILURE TO CORRECT DEFICIENCIES MAY RESULT IN ENFORCEMENT ACTION IN ACCORDANCE WITH THE PROVISIONS OF THE NEW JERSEY ADMINISTRATIVE CODE, TITLE 8, CHAPTER 43E, ENFORCEMENT OF LICENSURE REGULATIONS.	S 000		
S2230	8:39-31.6(b) Mandatory Physical Environment (b) Fire drills shall be conducted a total of 12 times per year, with at least one drill on each shift and one drill on a weekend. The facility shall attempt to have the local fire department participate in at least one fire drill per year. An actual alarm shall be considered a drill if it is documented. This REQUIREMENT is not met as evidenced by: Based on interview and record review on 7/24/19, in the presence of facility management, it was determined that the facility failed to conduct a fire drill on a weekend shift. This deficient practice was evidenced by the following:	S2230	S22030 Element One A weekend fire drill was immediately scheduled with the vendor and was conducted 0n July 27, 2019 on the 3-11 shift A meeting was held via phone on July	8/16/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Electronically Signed
TITLE
(X6) DATE 08/13/19

New Jersey Department of Health

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S2230	Continued From page 1 A review of the facility's fire drill documentation for the previous 12 months, revealed that the facility did not conduct a drill on a weekend shift. Further review, revealed that the last weekend shift drill was conducted by the vendor on 4/7/18, more than 15 months earlier.	S2230	25,2019 with the vendor, Administrator and the maintenance director to ensure at least one fire drill is conducted on the weekend per year. Element Two All Residents have the potential to be affected. Element Three The Maintenance Director annual fire drill log was updated to include a weekend fire drill a minimum of annually. Element Four The Maintenance Director and Administrator will review the fire drill logs monthly to assure compliance with drill requirements. Findings are discussed and corrective actions implemented as appropriate at the quarterly QA committee meeting.	