STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	315263		03/31/2022

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	F 000		
	Survey Date: 03/31/22 CENSUS: 161 SAMPLE SIZE: 34 An Onsite Revisit Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.			
F 577 SS=C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying	F 577		5/5/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/22/2022

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 IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	315263		03/31/2022

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 577	Continued From page 1 information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure that the State of New Jersey inspection results were readily accessible to residents on 3 of 3 units in the facility. This deficient practice was identified for 5 of 5 residents (Resident's #[redacted], and #[redacted]) during the 3/23/22 Resident Council group meeting and evidenced by the following: On 03/22/22 at 9:00 AM, the surveyor observed that a binder containing the State Survey inspection results (survey binder) was located near the front desk in the lobby of the facility. On 03/23/22 at 10:30 AM, the surveyor conducted a group meeting with five residents (Resident's #[redacted] #[redacted] #[redacted] and [redacted]) who were [redacted], and selected by the facility to attend the group meeting. Five of five residents stated that they were not aware of how or where to access the State Survey results. The surveyor stated there was a survey binder located near the front desk in the lobby of the facility. Four of five residents stated they did not have access to the lobby because a code was needed to open the door to the lobby. Review of the 12/22/21, 01/27/22, and 02/24/22 Resident Council Meeting minutes indicated that the survey binder was located in the front lobby and nursing units. During an interview with the surveyor on 03/23/22 at 12:22 PM, the Licensed Practical Nurse (LPN	F 577	Element 1 All survey books were located and placed on units and at front desk. Signs were placed announcing the placement of books. Element 2 All residents have the potential to be affected by this deficient practice. Element 3 Staff in serviced on placement of survey book. Residents were in serviced via Resident Council on placement of survey book and how to access. Element 4 Administrator /designee to assess for proper placement of survey book daily x 7 days, weekly x 4 and monthly x4 with findings reported monthly to the Quality Assurance performance Improvement committee for review and action as appropriate	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	315263		03/31/2022

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 577	Continued From page 2 #1) assigned to the [redacted]-Wing unit stated there was no survey binder on the [redacted]-Wing unit and that the survey binder was located in the front lobby. During an interview with the surveyor on 03/23/22 at 1:30 PM, LPN #2 stated there was no survey binder on the [redacted]-Wing unit and that the survey results were located in the front lobby. During an interview with the surveyor on 03/23/22 at 1:35 PM, LPN #3, who was assigned to the C-Wing unit, stated that she believed the survey binder was at the nursing station. The surveyor observed LPN #3 search through the binders and cabinets at the nursing desk but was unable to provide the surveyor with the survey binder. At that time, LPN #3 stated a survey binder was located in the front lobby. During an interview with the surveyor on 03/24/22 at 9:06 AM, the Director of Nursing (DON) stated survey binders were located on each unit and at the front desk. The DON further stated the staff were aware of the survey binders being located on each unit and in the front lobby. On 03/24/22 at 9:40 AM, the surveyor entered the copy room located behind the receptionist desk and observed staff with copies of the facility's past survey inspection results in hand. During an interview with the surveyor on 03/24/22 at 9:48 AM, the Licensed Practical Nurse/Unit Manager #2 (LPN/UM) stated there was no survey binder on the B-Wing unit and that the survey binder was located in the front lobby. During an interview with the surveyor on 03/24/22 at 9:50 AM, LPN/UM #3 stated that she wanted to	F 577		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	315263		03/31/2022

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 577	Continued From page 3 be sure the survey binder was not on the unit and wanted to reach out to someone to see where she could locate the survey binder. The surveyor observed LPN/UM #3, along with multiple other staff, search through binders and cabinets at the nursing station. The surveyor asked if any of the staff members present at the nursing station knew where the survey binder was located on the [redacted]-Wing unit. No one was able to provide an answer or locate the survey binder on the unit. LPN/UM #3 then stated that she would look in the locked medication room for the survey binder. LPN/UM #3 was not able to locate the survey result book on the [redacted]-Wing unit. On 03/24/22 at 10:03 AM, the surveyor observed the Unit Secretary (US) walking toward the [redacted]-Wing unit nursing station with a black binder in her hand. The US stated that she went to the front desk and got a copy of the survey binder. The US further stated it was her fault that the survey binder was not on the unit because she may have taken it up front by mistake. During an interview with the surveyor on 03/25/22 at 12:14 PM, the Administrator stated there was no facility policy that addressed the survey binder.	F 577		
F 582 SS=B	NJAC 8:39-9.4(b) Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of-	F 582		5/5/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	315263		03/31/2022

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 582	Continued From page 4 (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or	F 582		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	315263		03/31/2022

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 582	Continued From page 5 resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of other facility documentation, it was determined that the facility failed to provide the required Skilled Nursing Facility (SNF) Advance Beneficiary Notice (ABN) for 2 of 2 residents (Resident [redacted] and Resident [redacted]) reviewed for change in insurance coverage status and who remained in the facility. This deficient practice was evidenced by the following: On 03/22/22 at 11:45 AM, the surveyor reviewed the SNF Beneficiary Protection Notification Review (BPNR) forms, provided by the facility, for two residents (Resident [redacted]) who had a change in insurance coverage status and remained in the facility. At that time, the surveyor observed that both residents' SNF BPNR forms did not include a SNF ABN. Review of Resident [redacted]'s BPNR forms included the last covered day for Medicare Part A Services was [redacted] and the explanation of why the resident was not provided the SNF ABN was, "Medicai [Medicaid] Long Ter [Term]." Review of Resident [redacted]'s BPNR forms included the last covered day for Medicare Part A Services was [redacted] and the explanation of why the	F 582	Element 1 Director of SS was in-serviced on Medicaid/Medicare Coverage/liability notice ABN Element 2 All residents with Medicare coverage have the potential to be affected by this practice. Element 3 SS director was in serviced, discharge calendar was recreated to include last covered day and at that time the Liability notice will be distributed to any residents its applicable for. An audit was completed on all resident scheduled for Discharge/payor change. Element 4 SS director /designee will review all weekly discharges and ascertain need for ABN. An audit will be completed by Social Worker/designee to any residents its applicable for daily x 7 days, weekly x 4	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	315263		03/31/2022

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 582	Continued From page 6 resident was not provided the SNF ABN was, "Medicaid Long Term." During an interview with the surveyor on 03/24/22 at 10:22 AM, the Social Services Director (SSD) stated that the SNF ABN should be issued when the resident had Medicare days remaining and wanted to continue with therapy. The SSD added that both residents did not exhaust their 100 skilled days and were not issued the SNF ABN because they remained at the facility for LTC. The SS further stated she was not familiar with the SNF ABN and that she would issue the SNF ABN at the same time as the Notice of Medicare Non-coverage form. During an interview with the surveyor on 03/25/22 at 1:43 PM, the Vice President of Clinical Services stated there was no facility policy that addressed Beneficiary Protection Notifications. NJAC 8:39-4.1(a)(8)	F 582	and monthly x4 with findings reported monthly to the Quality Assurance performance Improvement committee for review and action as appropriate.	
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, interviews and record review, it was determined that the facility failed to a.) ensure a physician's order was accurately transcribed and signed on the Treatment Administration Record in accordance with professional standards of nursing practice for 1 of	F 658	Element 1 LPN #1 was immediately in serviced on transcribing orders, a transcription error report filled out and MD made aware.	5/5/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	315263		03/31/2022

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 658	Continued From page 7 34 residents (Resident [redacted]) and b.) ensure the Medication Administration Record was accurately signed in accordance with professional standards of nursing practice for 1 of 34 residents (Resident [redacted]). This deficient practice was evidenced as follows: 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 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." This deficient practice was evidenced by: 1. On 03/22/22 at 09:03 AM, the surveyor observed Resident [redacted] lying in bed and he/she	F 658	LPN #7 was immediately in serviced on transcribing orders, a transcription error report filled out and MD made aware. Element 2 All residents have the potential to be affected by this deficient practice. Element 3 Staff was re-in-serviced regarding transcribing orders, and an audit was completed by each unit manager utilizing POS(Physician order Summary), noting new medications/changes and if they were transcribed correctly including duration, date start /end. Element 4 UM□s/designee□s will review random 3 charts for any transcription errors of MD orders, daily x 7 days, weekly x 4 and monthly x4 with findings reported monthly to the Quality Assurance performance Improvement committee for review and action as appropriate.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	315263		03/31/2022

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 658	Continued From page 8 stated that he/she recently finished breakfast. Review of the Admission Record for Resident [redacted] revealed the resident was admitted to the facility with diagnoses, which included but were not limited to, [redacted] Review of Resident [redacted]'s Annual Minimum Data Set, an assessment tool utilized to facilitate the management of care, dated [redacted], revealed that the resident's Brief Interview of Mental Status score was [redacted], which indicated the resident was [redacted]. Review of the Physician Orders revealed a telephone verbal order dated [redacted] to apply [redacted] ointment protectant to [redacted] area BID (twice daily.) Review of the [redacted] Treatment Record (TR) did not reveal an order for the [redacted] ointment protectant. During an interview with the surveyor on 03/22/22 at 11:11 AM, the Licensed Practical Nurse #1 (LPN) stated that the nurse would call the physician for a treatment order, the order would get faxed to the pharmacy and then the order would be written on the TR. When the [redacted] TR was reviewed in the presence of LPN #1, she acknowledged she did not see the [redacted] ointment protectant order, dated [redacted], transcribed on the TR and stated she would write the order on the TR. She further stated that it was important to transcribe orders correctly to ensure treatments are being done.	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	315263		03/31/2022

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 658	Continued From page 9 During an interview with the surveyor on 03/22/22 at 11:17 AM, the LPN/Unit Manager #1 (LPN/UM), in the presence of LPN #1, acknowledged the physician order for [redacted] ointment protectant dated [redacted], and stated that once the treatment was ordered, it should have been transcribed on to the TR. The LPN/UM #1 observed the [redacted] TR and acknowledged the order was not transcribed. LPN #1 stated at that time that she forgot to write the order on the TR and was "putting it on now." The LPN/UM #1 stated it was important to transcribe orders correctly so that the residents are given the right care. During an interview with the surveyor on 03/22/22 at 11:28 AM, the Director of Nursing (DON) stated that it was the nurse's responsibility to transcribe physician orders to the TR. The DON observed the physician order for the [redacted] ointment protectant dated [redacted] and observed the [redacted] TR and acknowledged the order was on the TR. The surveyor informed the DON that after LPN #1 was made aware by the surveyor of the [redacted] ointment protectant order not being transcribed to the TR, that LPN #1 then transcribed the order to the TR and signed the 9:00 AM administration time for dates 03/17/22, 03/18/22, 03/19/22, 03/20/22, 03/21/22, and 03/22/22. The DON acknowledged that the LPN did not correctly transcribe the [redacted] ointment protectant order to the TR and stated it was important to transcribe orders correctly so there was no delay in care of the residents. During an interview with the surveyor on 03/22/22 at 11:36 AM, LPN #1, in the presence of the DON, LPN #1 stated the order for [redacted] ointment	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	315263		03/31/2022

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 658	Continued From page 10 protectant was not correctly transcribed to the TR and acknowledged that it was her responsibility to transcribe the order to the TR on [redacted]. LPN #1 further stated she just transcribed the order to the TR and signed her initials on the 9:00 AM administration times for dates 03/17/22, 03/18/22, 03/19/22, 03/20/22, 03/21/22, 03/22/22. Review of facility policy, "Medication Orders,", with a revision date of 03/24/22, revealed under Recording (Transcribing) Orders "8. Orders received by the Providers are transcribed on the Medication Administration Record (MAR) or the Treatment Administration Record (TAR) by the Nurse receiving the order." 2. On 03/18/22 12:14 PM, the surveyor observed Resident [redacted] sitting on side of the bed, eating lunch. Review of the Admission Record for Resident [redacted], revealed the resident was admitted to the facility with diagnoses, which included but were not limited to, [redacted] n the brain is disturbed, causing seizures). Review of the Physician Orders revealed a telephone verbal order dated [redacted] for an [redacted], [redacted] mg (milligrams) one tablet PO (by mouth) TID (three times a day) x 7 days. Review of the Interdisciplinary Progress Note, dated [redacted] at 11:00 PM, included, "resident returned from ER [Emergency Room].	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	315263		03/31/2022

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 658	Continued From page 11 [redacted] mg 1 PO TID x 7 days for [redacted]." Review of the [redacted] Medication Administration Record (MAR) included an order for [redacted] mg one PO TID x 7 day [redacted] dated [redacted] Further review of the MAR revealed the medication had been initialed on the MAR as being administered from 03/01/2022 until 03/10/2022 at "9 A (AM), 1 P (PM) and 5 P (PM)." During an interview with the surveyor on 03/22/22 at 12:10 PM, Licensed Practical Nurse (LPN) #7 stated that if there were nurse initials on the MAR, it meant that the medication had been administered. The surveyor and LPN #7 reviewed the [redacted] MAR and LPN #7 verified that the [redacted] was ordered on [redacted], but had been signed as administered by her on March 1, 2, and 3 at 9:00 AM, 1:00 PM, and 5:00 PM. LPN #7 further stated stated, "I don't know why I signed it." During an interview with the surveyor on 03/22/22 at 12:12 PM, the Licensed Practical Nurse/Unit Manager #1 (LPN/UM) stated that if nurse initials were there, it meant the medication was administered. The surveyor and LPN/UM #1 reviewed the [redacted] MAR and the surveyor showed the LPN/UM #1 the initials for March 1, 2, and 3 at 9:00 AM, 1:00 PM, and 5:00 PM for the Amoxicillin order. The LPN/UM #1 stated it meant the medication was administered. When the surveyor showed the LPN/UM #1 the order for the [redacted] dated [redacted] the LPN/UM #1 stated the medication could not have been given before the order date and should not have been signed as given.	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	315263		03/31/2022

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 658	Continued From page 12 During an interview with the surveyor on 03/24/22 at 9:07 AM, the Director of Nursing (DON) stated that if a medication on the MAR was initialed, it meant that the medication was given. The DON further stated that it was important to maintain accurate records so that it does not look like "we" gave something that "we" did not give. Review of the facility's undated policy, "Order, Receiving and Transcribing," revealed the Procedure: Medications shall be administered only upon the written order of a person duly licensed and authorized to prescribe such medications in this state. A review of the facility's policy, "Documentation of Medication Administration," revised 2021, revealed the Policy: The facility shall maintain a medication administration record to document all medications administered.	F 658		
F 684 SS=D	NJAC 8:39-29.2(d) Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 684		5/5/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	315263		03/31/2022

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 684	Continued From page 13 Based on observation, interview, record review, and review of other facility documentation, it was determined that facility staff failed to a.) complete neurological checks after a resident fall for 1 of 4 residents (Resident [redacted]) reviewed for accidents and b.) administer an [redacted] for a [redacted] [redacted] as ordered by the physician for 1 of 2 residents (Resident [redacted]) reviewed for [redacted] This deficient practice was evidenced by the following: 1. The surveyor observed Resident [redacted] lying in bed on the following dates and times: 03/17/22 at 11:22 AM, 03/18/22 at 12:11 PM and 2:08 PM, 03/21/22 at 10:47 AM, and 03/22/22 at 10:58 AM. According to the Admission Record, Resident [redacted] had a diagnosis that included, but was not limited to, [redacted] The surveyor requested, obtained, and reviewed a copy of the instructions associated with the process of completing an incident report. The instructions indicated that a report is to be completed for unwitnessed falls and specified, "[redacted] checks are to be initiated with all [redacted]." Further review of the report instructions revealed a need to perform [redacted] assessments every 15 minutes for two hours, then every 30 minutes for two hours, followed by every 60 minutes for four hours, and every eight hours for 16 hours "[redacted]". The surveyor obtained and reviewed a document titled, "Incident/Accident Report" for Resident [redacted] dated [redacted] at 11:00 AM. According to the	F 684	ELEMENT 1 MD made aware of lack of [redacted] check completion from [redacted] on [redacted] of resident [redacted], and staff in- serviced on neurological assessments(checks). Resident [redacted] Facility is not able to go back retroactively to fix the [redacted] check form. Facility is not able to go back retroactively to correct the deficit practice for Resident [redacted] Element 2 All residents in need of [redacted] assessments have the potential to be affected by this deficient practice. All residents in need of [redacted] have the potential to be affected by this deficient practice Element 3 Staff were in-serviced on [redacted] assessments including duration of [redacted] assessment, initiation, and completeness of form/assessment. All incidents /accidents will be reviewed by the IDCP(Interdisciplinary Care Team) team for completion (if applicable) of [redacted] assessment for initiation, duration, and completeness. Staff were in-serviced on starting the [redacted] as soon the medication is prescribed by the Physician	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	315263		03/31/2022

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 684	Continued From page 14 referenced report, Resident [redacted] was found on the floor, in a sitting position, in front of his/her [redacted] chair (a large, padded chair that is designed to help elderly individuals with [redacted]). Further review of the report revealed [redacted] I checks were conducted for a period beginning on [redacted] at 11:00 AM until 10:00 PM on the same date. A review of the current Care Plan for Resident [redacted] revealed n[redacted] checks were in place, related to the referenced [redacted] on [redacted] During an interview with the surveyor on 03/23/22 at 10:45 AM, the Director of Nursing (DON) confirmed that the [redacted] assessments attached to the "Incident/Accident Report" were those conducted on Resident [redacted] and clarified that the name was not filled out as it should have been, since all the pages are stapled together. During an interview with the surveyor on 03/24/22 at 11:12 AM, the Licensed Practical Nurse/Unit Manager #2 (LPN/UM) described the process for investigating an unwitnessed fall. LPN/UM #2 confirmed the process included conducting neurological assessments because there is uncertainty as to the status of a resident's [redacted] if a [redacted] was not witnessed and it is important for determining the absence of presence of [redacted]. LPN/UM #2 could not recall the exact time intervals required of a neurological assessment but stated it was important to follow the protocol as written on the incident report guidance. In addition, LPN/UM #2 was able to verify that the copy of the incident report and associated [redacted] assessment information provided to the surveyor was current and the process for conducting [redacted] assessments	F 684	Element 4 All incidents /accidents will be reviewed by the IDCP(Interdisciplinary Care Team) team for completion (if applicable) of [redacted] assessment for initiation, duration, and completeness, daily x14 days, weekly x 4 and monthly x4 with findings reported monthly to the Quality Assurance performance Improvement committee for review and action as appropriate. Infection Preventionist will audit 5 residents medication administration record of residents on [redacted] therapy and ensure that the medication was administered as ordered by the physician daily x1 week weekly x4 and monthly x4 with findings reported monthly to the Quality Assurance performance Improvement committee for review and action as appropriate.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	315263		03/31/2022

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 684	Continued From page 15 should last for a period of 24 hours in total. During the same interview, LPN/UM #2 reviewed the "Incident/Accident Report" dated 02/18/22 for Resident [redacted]. LPN/UM #2 reiterated the importance of conducting [redacted] assessments thoroughly. LPN/UM #2 further acknowledged that the [redacted] assessments conducted for Resident #[redacted] on the referenced date were done only for approximately 11 hours (less than 24 hours), that the assessments were incomplete, and did not know why all nursing staff who participated in the process of conducting them did not sign the sheet accordingly. LPN/UM #2 stated that the incomplete and inconsistent documentation on the form may have been the result of the nurse's day and what type of other care may have been needed by other residents. During an interview with the surveyor on 03/24/22 at 12:05 PM, the DON described the process of events that should occur after a resident has an [redacted], which included the need to follow the [redacted] assessments as previously described per the referenced protocol. The DON stated that if [redacted] assessments did not occur, this would be considered a problem because it is necessary to ensure the resident is stable, that there is no head injury, and there are no [redacted] problems present. The DON also acknowledged that [redacted] assessments did not occur for 24 hours, per the facility's protocol, and could not provide any further explanation regarding the matter. During a follow-up interview with the surveyor on 03/24/22 at 3:07 PM, the DON reiterated the importance of conducting [redacted] assessments for an [redacted] and	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	315263		03/31/2022

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 684	Continued From page 16 acknowledged that a resident who was found on the floor would be considered as one who experienced an [redacted]. The surveyor, in the presence of the survey team and the facility administrative staff, asked for any additional details that may be relevant to the circumstances described. During a follow-up interview with the surveyor on 03/25/22 at approximately 2:00 PM, the DON followed-up with the surveyor, in the presence of the survey team and facility administrative staff. The DON indicated that there was no additional information regarding the referenced matter. Review of the facility policy titled, "The Palace Rehabilitation and Care Center [redacted] Assessment," with a revision date of 11/01/21, reflected [redacted] assessments are indicated following an [redacted], and they are to be performed per the [redacted] protocol. In addition, there is information that should be included in the resident's medical record as related to [redacted] assessments, including the date and time the procedure was performed, the name and title of the individual performing the procedure, and the signature and title of the person recording the data. Review of the facility policy titled, "Accident/Incident Policy," with a revision date of 11/01/21, reflected the importance of completing an "Accident/Incident Form" each time a resident experiences an unusual circumstance that causes or could cause injury. One such example included a resident found sitting on the floor and the need to perform [redacted] checks as indicated.	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	315263		03/31/2022

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 684	Continued From page 17	F 684		

2. On 03/18/2022 at 12:21 PM, the surveyor observed Resident [redacted] awake and alert sitting in his/her wheelchair in the resident's room. The surveyor observed Resident [redacted] with a [redacted] to the [redacted] and the resident stated that the nurses perform dressing changes to his/her [redacted] The surveyor further observed the Resident [redacted] sitting in his/her wheelchair with a [redacted] on the [redacted] on 03/21/22 at 10:20 AM, 03/21/22 at 1:03 PM, and 03/22/22 10:45 AM.

According to the Resident Face Sheet, Resident [redacted] was admitted to the facility with diagnoses which included, but not limited to, [redacted]

A review of the Quarterly Minimum Data Set (MDS), an assessment tool utilized to facilitate the management of care, dated [redacted], revealed that Resident [redacted] had a Brief Interview for Mental Status score of 1[redacted] indicating the resident was [redacted] The MDS further reflected Resident # [redacted] had a current diagnosis of [redacted]

Review of the [redacted] care consultants report included a recommendation to start [redacted]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	315263		03/31/2022

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 684	Continued From page 18 (an [redacted] milligrams (mg) po (by mouth) bid (twice a day) for [redacted] days. Review of the physician order dated [redacted] revealed a telephone verbal order for the [redacted] mg po bid for [redacted] days for a [redacted] Review of the [redacted] Medication Administration Record (MAR) revealed signatures that the administration for the [redacted] did not start until [redacted] at 9:00 AM. Review of the Nurses notes dated [redacted] through [redacted] reflected that [redacted] were in progress. During an interview with the surveyor on 03/24/22 at 10:55 AM, the Director of Nursing (DON) reviewed the [redacted] MAR and confirmed the [redacted] was not signed as administered until 01/27/22 at 9:00 AM. The DON further stated that if an [redacted] was ordered, and the facility has it in the [redacted] back up pharmacy box, then the [redacted] should be started on the same day it was ordered. If the facility does not have the medication in the back up pharmacy box, then the nurses should call the doctor to get another medication ordered that was in stock. During an interview with the surveyor on 03/25/22 at 9:39 AM, Licensed Practical Nurse #5 (LPN) stated, "When a resident is ordered a new [redacted], I would get the medication from the back up [redacted] box which is located on the A-Wing unit. I would sign out the [redacted] from the back up box and administer it that day it was ordered. If we don't have the medication in the back up box, I would call the doctor to get the	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	315263		03/31/2022

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 684	Continued From page 19 order changed or get an order to start the antibiotic when it comes from the pharmacy." During an interview with the surveyor on 03/25/22 at 10:03 AM, the LPN Unit Manager #1 (LPN/UM) stated the [redacted] back up box was stored in the locked medication unit on the [redacted] Wing unit. LPN/UM #1, along with the surveyor, reviewed the locked [redacted] backup box and the list of medications contained in the back up box. LPN/UM #1 confirmed that [redacted] mg tablets were included in the [redacted] back up box. LPN/UM #1 stated that when an [redacted] was ordered, the nurse would take out the [redacted] from the back up box, fill out the replacement form with the quantity used, date and initial the form and fax the form to the pharmacy. LPN/UM #1 provided the surveyor with a backup replacement form, dated [redacted], which revealed [redacted] mg was removed on [redacted] by the nurse. LPN/UM #1 could not provide any additional replacement forms for Resident [redacted], During a telephone interview with the surveyor on 03/25/22 at 10:59 AM, the provider pharmacist stated that the order for [redacted] mg was filled by the pharmacy on [redacted] and delivered to the facility that evening. Review of the pharmacy packing slip revealed that the [redacted] mg tablets were delivered to the facility on [redacted] at 10:53 AM. During a follow-up interview with the surveyor on 03/25/22 at 12:58 PM, the DON stated that when an [redacted] was ordered, the nurse should administer the medication on the day it was ordered if the [redacted] was available. The DON further stated that it was important to start an	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	315263		03/31/2022

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 684	Continued From page 20 [redacted] when ordered because if there was an [redacted] you would want to resolve it as soon as possible. Review of the facility's policy titled "Documentation of Medication Administration," revised 2021, reflected that documentation of administration of medication should include the reason(s) why a medication was withheld, not administered, or refused (as applicable).	F 684		
F 692 SS=E	NJAC 8:39-27.1(a) and 8:39-29.2(d) Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by:	F 692		5/5/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	315263		03/31/2022

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 692	Continued From page 21 Based on observation, interview, record review, and review of other facility documentation, it was determined that the facility failed to notify the physician of a significant, unplanned [redacted] for 1 of 4 residents (Resident [redacted] reviewed for nutritional status. This deficient practice was evidenced by: On 03/18/22 at 12:21 PM, the surveyor observed Resident [redacted] seated in a chair at the bedside eating lunch. The resident did not respond verbally to the surveyor when spoken to. The resident's roommate who was present, informed the surveyor that the resident [redacted]. The resident did not respond to a Temporary Nursing Aide, who greeted the resident in his/her [redacted]. The surveyor observed the resident ate 100% of his/her meal. On 03/21/22 at 12:17 PM, the surveyor observed Resident [redacted] was being fed by Licensed Practical Nurse (LPN) #6, in the presence of LPN/Unit Manager (LPN/UM) #3 who encouraged the resident to eat. LPN/UM #3 stated that the resident was tired and she wanted to ensure that he/she ate. She further stated that the resident had eaten everything except for a slice of wheat bread. According to the Admission Record, Resident [redacted] was admitted to the facility with diagnoses which included, but were not limited to, [redacted] and [redacted] Review of Resident [redacted] quarterly Minimum	F 692	Element 1 MD and family of resident [redacted] was immediately made aware of resident [redacted] and interventions in place. Resident [redacted] was placed on a meal monitoring program followed by a [redacted] count. RD reevaluated and adjusted interventions. Element 2 All residents have the potential to be affected by this deficient practice. Element 3 Dietician was immediately in-serviced by Senior RD on nutritional assessments, [redacted] documentation, and interventions. [redacted] team in-serviced on documentation of [redacted], and coordination with RD. A facility wide weight audit was completed by IDCP(interdisciplinary care team) team led by RD, all residents with [redacted] of [redacted] or more had repeat RD assessment and interventions adjusted as needed. Element 4 RD/designee will audit all units for [redacted]t documentation, ensure interventions are in place and report findings to weekly [redacted] team meeting. Don/designee to review weekly documentation from RD and ensure interventions are in place/effective weekly x 8 and monthly x4 with findings reported monthly to the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	315263		03/31/2022

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 692	Continued From page 22 Data Set (MDS), an assessment tool utilized to facilitate the management of care, dated [redacted], reflected that the resident had a Brief Interview for Mental Status score of [redacted] indicating that the resident was [redacted]. Further review of the MDS revealed that the resident's height was [redacted] inches and the resident's weight was [redacted] pounds (lb.), which was coded as a [redacted] or more in the last month or loss of [redacted] or more in last [redacted]" and the resident was not on a physician-prescribed [redacted] regimen. Review of Resident [redacted] Care Plan revealed an entry dated [redacted], indicating that the resident had a potential for [redacted] and [redacted]. The "Goal" reflected that Resident [redacted] was to [redacted] with "Interventions" that included Dietary Consult for consistent meal completion of [redacted]. During an interview with the surveyor on 03/18/22 at 12:48 PM, the Dietician stated that Resident [redacted] was [redacted] and that the resident was [redacted] inches tall, weighed [redacted] lb. upon admission, and had an ideal body weight of [redacted] lb. The Dietician further stated that the plan was to maintain the resident's weight at the resident's Body Mass Index (BMI), a value derived from the mass and height of a person, which was [redacted] and that right now the resident's weight was "perfect." Review of Resident [redacted]s Weight summary, contained within the Electronic Health Record (EHR), revealed the following: On [redacted], the resident weighed [redacted] lb. On [redacted], the resident weighed [redacted] lb.	F 692	Quality Assurance performance Improvement committee for review and action as appropriate.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	315263		03/31/2022

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 692	Continued From page 23 On [redacted], the resident weighed [redacted] lb. On [redacted], the resident weighed [redacted] lb. On [redacted], the resident weighed [redacted] lb. with a notification of "Warnings: [redacted] change [Comparison Weight [redacted] lb., [redacted] lb.]" On [redacted], the resident weighed [redacted] lb. On [redacted] the resident weighed [redacted] lb. with a notification of "Warnings: [redacted] change [Comparison weight [redacted] lb., [redacted], [redacted] lb.] - [redacted] change [Comparison weight [redacted] lb., - [redacted] lb.]" On [redacted], the resident weighed [redacted] lb. with a notification of "Warnings: [redacted] change [comparison weight [redacted] lb., [redacted] lb.]" Further review of the Weight Summary revealed that the resident's weight was not recorded in [redacted] or [redacted] During an interview with the surveyor on 03/23/22 at 1:41 PM, the Dietician stated that Resident [redacted] weighed [redacted] lb. in [redacted] and [redacted] lb. in [redacted]. She further stated that a [redacted] was identified in [redacted] and acknowledged that she did not document the [redacted] in the resident's record. The dietician also stated that the facility held weekly weight meetings that were attended by the Director of Nursing (DON) and the Administrator. During an interview with the surveyor on 03/24/22 at 08:33 AM, in the presence of the survey team, the DON stated that weekly weight meetings were held every Friday, and the Dietician, DON, Unit Managers (UM), and MDS Coordinator attended. The DON further stated that the Certified Nursing Assistants (CNAs) documented the resident	F 692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	315263		03/31/2022

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 692	Continued From page 24 weights on paper and the UMs put the weights on the chart and reviewed them before they were documented in the EHR. The DON then stated that the physician was notified of any weight loss or gain and that the Dietician was required to complete a Nutritional Alert Sheet and place it within the resident's chart. The DON stated that she did not recall discussing this resident with the Dietician and that the policy was not followed if the physician and family were not notified of the significant weight change. During an interview with the surveyor on 03/24/22 at 09:02 AM, LPN/UM #3 stated that Resident [redacted] weighed [redacted] lb. yesterday and that on 03/23/22, the Dietician implemented a Nutritional Alert Sheet to the Attending Physician and Nursing for [redacted]. She stated that the facility policy required that the Dietician, Physician, and family were notified of a [redacted] pound weight loss or gain. LPN/UM #3 further stated that she saw that the Nutritional Alert Sheet was completed today, and she notified the physician's Advanced Practice Nurse of the Dietician's recommendations and an order was obtained for implementation. LPN/UM #3 also stated that she left a message for the resident's family. During an interview with the surveyor on 03/24/22 at 10:43 AM, the Registered Nurse Assessment Coordinator (RNAC) stated that she did not attend weekly weight meetings but did work with both the Dietician and UM to obtain accurate weights. The RNAC further stated that she did not remember Resident [redacted] having any [redacted] or nutritional concerns and that the Dietician filled out the Nutrition portion of the MDS Assessment under [redacted]	F 692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	315263		03/31/2022

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 692	Continued From page 25 During an interview with the surveyor on 03/24/22 at 12:34 PM, in the presence of the DON, the Dietician stated that in [redacted] a desirable [redacted]-pound [redacted] was identified and weekly weights were implemented. The DON stated that the nurses normally phoned the physician to report [redacted], once a [redacted]-pound [redacted] was identified and that the resident should have been weighed weekly thereafter in accordance with the facility policy. During a telephone interview with the surveyor on 03/25/22 at 10:49 AM, in the presence of the survey team, the physician's Advanced Practice Nurse stated that Resident [redacted] had [redacted], was [redacted] He stated that the facility's LPN/UM #3 phoned him yesterday and informed him that the resident had a [redacted] pound [redacted], and he told LPN/UM #3 that the resident should be seen by the Dietician to ensure that interventions were in place, such as supplements if needed, before he ordered any medications or labs. The Advanced Practice Nurse further stated that he was not aware of any [redacted] until recently. The Advanced Practice Nurse then stated that with a [redacted] pound [redacted], "I am surprised that I was not notified and the Dietician should have also been notified." The Advanced Practice Nurse further stated the facility would not have contacted the attending physician, as the facility primarily contacted him. During a telephone interview with the surveyor on 03/25/22 at 11:35 AM, in the presence of the survey team, the physician stated that he was not directly contacted regarding Resident [redacted] and stated that the Advanced Practice Nurse was the primary contact for the facility. The	F 692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	315263		03/31/2022

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 692	Continued From page 26 physician further stated that he depended on the nursing staff to report a resident's [redacted]. He further stated that the Advanced Practice Nurse visited the facility two to three times per week and no one informed him of any [redacted]. During a follow-up interview with the surveyor on 03/25/22 at 12:21 PM, the DON described the process for informing the physician of a resident's [redacted]. She stated that the following factors are considered by staff, prior to informing the physician of a possible [redacted]: noted [redacted]t [redacted], the resident's BMI, and if the weight loss was considered desirable. The DON further stated that she did not know off hand if the physician was notified of Resident [redacted]. She further stated that the physician should have been notified prior to yesterday. During an interview with the surveyor on 03/25/22 at 01:53 PM, in the presence of the survey team, the Regional Vice President of Clinical Services (RVPCS), DON and Administrator declined to comment whether the physician should have been contacted, on or around [redacted], when the MDS was coded to demonstrate that the resident had a [redacted] of [redacted] or more in the last month or loss of [redacted] or more in the past [redacted] months, while not on a physician-prescribed [redacted] regimen." Review of a facility policy titled, "Weight Assessment and Intervention," revised 07/16/21 revealed the following: The multidisciplinary team will strive to prevent, monitor, and intervene for undesirable [redacted] for our residents.	F 692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	315263		03/31/2022

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 692	Continued From page 27 The threshold for significant unplanned and undesired [redacted] will be based on the following criteria [where percentage of body [redacted] = (usual weight-actual weight)/ (usual weight) x 100]: a. 1 month-[redacted] is significant; greater than [redacted] is severe. [redacted] months-[redacted] is significant; greater than [redacted] is severe. [redacted] months-[redacted] is significant; greater than [redacted] is severe. 1. Assessment information shall be analyzed by the multidisciplinary team and conclusions shall be made regarding the: a. Resident's target weight range (including rationale if different from ideal body weight); b. Approximate calorie, protein, and other nutrient needs compared with the resident's current intake; c. The relationship between current medical condition or clinical situation and recent fluctuations in weight; and d. Whether and to what extent weight stabilization or improvement can be anticipated. 2. The Physician and the multidisciplinary team will identify conditions and medications that may be causing [redacted] or increasing the risk of weight loss. For example: a. Cognitive or functional decline; b. Chewing or swallowing abnormalities; c. Pain; d. Medication-related adverse consequences; e. Environmental factors (such as noise or distractions related to dining); f. Increased need for calories and/or protein; g. Poor digestion and absorption; h. Fluid and nutrient loss; and/or i. Inadequate availability of food and fluids.	F 692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	315263		03/31/2022

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 692	Continued From page 28 The surveyor noted that the facility's Weight Assessment and Intervention policy did not reflect that the physician be notified for a resident's change in weight.	F 692		
F 755 SS=E	NJAC 8:39-17.1(c), 17.2(d), 27.2 (e) Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in	F 755		5/5/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	315263		03/31/2022

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 755	Continued From page 29 order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of other facility documentation, it was determined that the facility failed to a.) clarify a standing [redacted]t order for 1 of 5 residents (Resident [redacted]) reviewed for unnecessary medications, b.) ensure accurate completion of a Drug Enforcement Agency (DEA) Form-222 (a federal narcotic requisition form), to enable accurate reconciliation of controlled-dangerous substances (medications, that due to their high potential for abuse, are tracked with a degree of detail and attention) for 4 of 4 forms reviewed, c.) ensure the Medication Administration Record (MAR) was signed after the administration of medications for 1 of 6 residents (Resident [redacted] by 1 of 3 nurses observed during medication pass, d.) ensure the medication nurse consistently followed the cautionary instruction for medications administered for 2 of 6 residents (Resident's [redacted] and [redacted]) by 1 of 3 nurses during medication pass, and e.) ensure a new physician order was transcribed onto the physicians order form for 1 of 6 residents (Resident [redacted] observed during medication pass. The deficient practice was evidenced by the following: 1. According to the resident's Admission Record, Resident [redacted] had diagnoses including, but not limited to, [redacted]	F 755	Element 1 Resident [redacted] dose was immediately clarified. DEA 222 form was immediately reconciled with pharmacy for amount of medication received and lot number on DEA 222. Resident [redacted] MAR was updated (signed) via late entry signature. LPN #5 Immediately in-serviced on medication directions/precautions. MD□s of resident #□s [redacted] notified of residents not rinsing mouth post inhalation of medication per pharmacy directions. Resident [redacted] POS was immediately updated to dose of medication LPN #1 was immediately in serviced on updating and documenting MD orders to reflect current dosing. Element 2 All residents have the potential to be affected by this deficient practice. Element 3 DON was in serviced on reconciling DEA 222 and form number with pharmacy. Nursing staff was in-serviced on medication transcription, including	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	315263		03/31/2022

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 755	Continued From page 30 Resident [redacted] was readmitted to the facility on [redacted] Review of the September [redacted] handwritten Physician's Orders (PO), signed by the physician, revealed an undated order for [redacted] medication) [redacted] mg/ml every [redacted] hours [redacted] for diagnosis [redacted]. The surveyor observed the order did not include the dose (amount of the medication) to be administered in milliliters. Review of the handwritten [redacted] MAR reflected that the undated physician order was transcribed on to the [redacted] MAR as [redacted] mg/ml every [redacted] hours [redacted] for Diagnosis [redacted] The times plotted for administration were 9:00 AM and 9:00 PM. The medication was administered two times daily from 09/15/21 through 09/20/21, from 09/22/21 through 09/26/21 and from 09/28/21 through 09/30/21. The medication was administered at 9:00 PM daily on 09/21/21 and 09/27/21, with the 9:00 AM dose not signed. The surveyor observed the order did not include the dose to be administered. On 09/20/21, the Pharmacy Consultant (PC) made a recommendation to "Clarify [redacted]." The surveyor observed the medication continued to be administered from 09/22/21 through 09/30/21. During an interview with the surveyor on 03/22/22 at 12:15 PM, the Licensed Practical Nurse/Unit Manager #2 (LPN/UM) and the surveyor reviewed the [redacted] PO and the [redacted] MAR. LPN/UM #2 confirmed that the order did not include the dose of [redacted] to be administered to the resident. She stated that the nurse should have clarified	F 755	documenting administration of medication, following medication administration precautions, and updating and documenting MD orders. Element 4 Pharmacy consultant/designee to complete MED pass weekly on 2 nurses until all RN/LPN have completed med pass observations. Findings will be reported to DON at the time of pharmacy med pass and DON will review immediately and adjust schedule as needed. Regional DON to review Monthly pharmacy consultant reports for completion, and DEA 222 forms for reflection of medication received, monthly x6 with findings reported monthly to the Quality Assurance performance Improvement committee for review and action as appropriate.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	315263		03/31/2022

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 755	Continued From page 31 the order. LPN/UM #2 further stated that if the MAR was not signed for the 9:00 AM dose on 09/21/21 and 09/27/21, the medication was not administered. The nurse should have signed the MAR when the medication was administered. During an interview with the surveyors on 03/24/22 at 8:50 AM, the Director of Nursing (DON) reviewed the [redacted] PO and [redacted] MAR. The DON confirmed that the order did not include the dose of the medication to be administered and further stated that the nurse should have clarified the order to include the dose. The DON confirmed the nurse should sign the MAR when a medication is administered. Review of the facility's Medication Orders policy, dated 02/01/22, reflected "Medication Orders - When recording orders for medication, specify: a. The type, route, dosage, frequency and strength of the medication ordered (i.e., Dilantin 100 mg p.o. [by mouth] t.i.d. [three times daily])." 2. On 03/25/22 at 11:00 AM, a review of the facility's DEA Form-222 documents revealed the facility staff did not complete the "last line completed" section in Part 1 or the "number of packages received" and the "date the medication was received" in Part 5, as instructed on the face of DEA Form-222, within each section and in accordance with the stepwise directions referenced on the back of each form. The inaccuracies were as follows: The DEA Form-222 documents dated [redacted] and [redacted] did not include the last line completed on the bottom, left-side corner of the	F 755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	315263		03/31/2022

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 755	Continued From page 32 form. The DEA Form-222 documents dated [redacted], 02/17/22, and 03/03/22 did not indicate the number received or the date received for any of the items ordered. The DEA Form-222 document dated [redacted] did not indicate the number received for all items or the date received for any of the items ordered. An additional copy of the same form revealed the number of items received for two of the items, but none of the seven other items referenced on the form. Review of the DEA Form-222 documents also revealed the same order number for two of the forms. Order Form Number 201273204 was present on the form dated [redacted] and [redacted]. During an interview with the surveyor and survey team on 03/25/22 at 2:30 PM, the Director of Nursing (DON) stated that there were copies of the forms in which the last line was not filled out but that she subsequently filled this section out completely, when asked to do so by the pharmacy staff; however, she was not able to provide such copies. The DON further acknowledged that the provided DEA Form-222 documents were incomplete, apologized for the blanks, and stated she was accustomed to using an automated dispensing pharmacy machine. Finally, the DON stated that one of the forms, dated [redacted], was partially completed for the number of the items received, during the process of checking the delivered medication but, once again, acknowledged the form was incomplete and could not provide any further detail regarding the matter. During a telephone interview with the surveyor,	F 755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	315263		03/31/2022

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 755	Continued From page 33 the Assistant Director of Nursing (ADON) and DON on 03/31/22 at 12:28 PM, the surveyor asked questions regarding the use of a DEA-222 Form with the same order form number and different dates, as referenced. The ADON acknowledged that the order form numbers were the same, but did not know why, stating it was possibly due to an extra copy of the form. The DON stated that she simply uses the forms provided to them by the pharmacy and did not know anything further. The DON additionally stated she would bring this to the attention of the staff at the facility's provider pharmacy. Review of the back of DEA Form-222 revealed, "Instructions for DEA Form 222" with multiple parts and steps. The directions included to enter the total number of line items ordered in Part 1, number 3. The directions also included a need to enter the number of packages received and the date received for each line item in Part 5, number 2. Review of the facility's policy titled, "Controlled Substances" revealed "2021" as the most recent revision date. The policy indicated that it was necessary for the facility to comply with all laws, regulations, and other requirements related to the handling, storage, disposal, and documentation of Schedule II and other controlled substances. In addition, the policy revealed that controlled substances must be counted upon delivery. 3. On 03/23/22 at 8:59 AM, the surveyor observed the Licensed Practical Nurse #4 (LPN) prepare three medications for Resident [redacted] LPN #4 placed a "dot" mark with her pen in the resident's [redacted] MAR in the "Date/Time Block."	F 755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	315263		03/31/2022

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 755	Continued From page 34 (The MAR delineates each ordered medication with scheduled administration time(s) and a "block" for the LPN to initial coordinating the medication, the administration time and the day of the month). The surveyor observed LPN #4 administered the medications to the resident, but she did not initial the Date/Time Block in the resident's [redacted] MAR for each medication administered. On 03/23/22 at 9:04 AM, the surveyor observed LPN #4 pour one medication for Resident [redacted]. At which time, the surveyor questioned if she signed the MAR for Resident [redacted]. LPN #4 reviewed Resident [redacted]s MAR, in the presence of the surveyor, and confirmed that she had not signed the MAR after administering the resident's medications. LPN #4 stated she placed a "dot" in the box to remind her to sign for the medications administered. LPN #4 further stated that she was supposed to sign the MAR after administering the medication to the resident. 4. On 03/23/22 at 9:24 AM, the surveyor observed LPN #5 prepare four medications for Resident [redacted]. The surveyor observed that the resident's [redacted] MAR contained an order for [redacted] mcg (microgram) (a [redacted] that helps prevent symptoms of [redacted] and to [redacted] orally daily for [redacted]. The MAR contained a cautionary instruction (a method or procedure intended to prevent or avoid adverse outcomes with medication administration) t [redacted] USE." The surveyor observed LPN #5 administer the medications to the resident. During	F 755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	315263		03/31/2022

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 755	Continued From page 35 administration of the resident's medications, LPN #5 handed Resident [redacted] the [redacted] the resident inhaled the medication and handed the [redacted] back to LPN #5. LPN #5 administered the remaining medications to the resident and exited the room. LPN #5 did not offer or instruct the resident to [redacted] his/her [redacted] thoroughly after the administration of the [redacted]. On 03/23/22 at 9:33 AM, the surveyor observed LPN #5 prepare eight medications for Resident [redacted] The surveyor observed that the resident's [redacted] MAR contained an order for [redacted] [mcg] (a [redacted] used to treat [redacted] in patients with [redacted] and [redacted]) and to administer [redacted] orally daily for [redacted] The MAR contained a cautionary instruction to [redacted]." The surveyor observed LPN #5 administer the medications to the resident. During administration of the resident's medications, LPN #5 handed Resident [redacted] the [redacted], the resident [redacted] the medication and handed the [redacted] back to LPN #5. LPN #5 administered the remaining medications to the resident and exited the room. LPN #5 did not offer or instruct the resident to [redacted] his/her [redacted] thoroughly after the administration of the [redacted]. During an interview with the surveyor on 03/23/22 at 12:06 PM, Resident [redacted] stated that nursing never instructed him/her to [redacted] his/her [redacted] thoroughly after taking the [redacted]. During an interview with the surveyor on 03/23/22 at 12:09 PM, Resident [redacted] resident stated that the nurse may have instructed him/her to [redacted] his/her [redacted]. At which time, Resident [redacted]	F 755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	315263		03/31/2022

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 755	Continued From page 36 confirmed that LPN #5 did not instruct him/her to [redacted] his/her [redacted] thoroughly after taking the [redacted] that morning. During an interview with the surveyor on 03/23/22 at 12:11 PM, LPN #5 stated the nurse should instruct the resident to [redacted] after the administration of an [redacted]r, especially if the [redacted] contained a [redacted] LPN #5 added that [redacted] can cause [redacted]) if you do not [redacted] the mouth after administration. LPN #5 stated that she did not remember instructing the residents to [redacted] their [redacted] after administering the inhalers and that she should have instructed the residents to [redacted] their [redacted]. 5. On 03/23/22 at 9:24 AM, the surveyor observed LPN #1 prepare four medications for Resident [redacted]. The medications prepared included the following: [redacted] milligrams (mg) [redacted] medication), [redacted] mg ([redacted] medication), [redacted] mg ([redacted] medication), and [redacted] mg (a narcotic used to treat [redacted] The surveyor observed LPN #1 administer the medications to the resident and returned to medication cart to sign the MAR. On 03/23/22 at 12:40 PM, the surveyor completed the medication reconciliation for Resident [redacted]s medication administration observation. Review of the Physician Order Sheets (POS) did not reveal a Physician Order (PO) for the [redacted] mg medication that was administered during the medication pass observation with LPN #1.	F 755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	315263		03/31/2022

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 755	Continued From page 37 Review of Resident #[redacted]'s MAR revealed a PO, dated [redacted], for [redacted] mg to administer one bottle daily. The MAR revealed that the nurses signed the medication as administered on the following dates: 03/21/22, 03/22/22, and 03/23/22. During an interview with the surveyor on 03/23/22 at 12:49 PM, LPN #1 reviewed Resident [redacted]'s POS, in the presence of the surveyor, and confirmed the surveyor's findings. LPN #1 was unable to locate a [redacted] PO for [redacted] mg daily in the resident's medical record. LPN #1 stated that she only saw an PO for the previous [redacted] mg dose. LPN #1 further stated Resident [redacted] dose was recently increased and that a PO for [redacted] mg should have been written on the resident's POS. LPN #1 stated the nurse who received the medication was responsible for transcribing the new [redacted] order onto the resident's POS and MAR. LPN #1 added that a nurse would go to the [redacted] clinic to pick up the medications for the residents. Upon return to facility, that nurse would then distribute the medications to the nurses on the units. A declining sheet is completed and placed into the narcotic book for accountability. LPN #1 stated the [redacted] clinic determined the dosage for each resident and sends a prescription electronically to the pharmacy directly. LPN #1 reiterated that it was the responsibility of the receiving nurse to write the new PO onto the POS when the medication was increased. During an interview with the surveyor on 03/24/22 at 8:57 AM, the Director of Nursing (DON) stated a Unit Manager goes to the [redacted] clinic to	F 755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	315263		03/31/2022

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 755	Continued From page 38 pick up the medications for the residents and disperses them to the nurses on the units. The DON further stated that the [redacted] dosage was determined by the [redacted] clinic and that it was the responsibility of the receiving nurse to document the PO onto the POS. The nurse would then transcribe the PO onto the resident's MAR. The DON added that any change in the [redacted] dosage would require the nurse to update the POS, MAR and send a fax of the new PO to the pharmacy. During a follow up interview with the surveyor on 03/24/22 at 11:04 AM, the DON stated she expected the nurse to sign the MAR after administering the medications to the resident. The DON further stated that she expected nurses to follow the cautionary instruction on the MAR and that the cautionary instructions ensured that there would be no adverse reaction. Review of the facility's "Documentation of Medication Administration" policy, revised in 2021, indicated the nurse should document all medication administered to each resident on the resident's MAR. The policy further indicated that the administration of medication must be documented immediately after given. Review of the facility's undated "Order, Receiving and Transcribing Physician Medication Orders" policy revealed that drugs and biological orders must be recorded on the POS in the resident's chart. NJAC 8:39-11.2(b); 29.2(a)(d); 29.3	F 755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	315263		03/31/2022

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 755	Continued From page 39 29.7	F 755		
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in	F 756		5/5/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	315263		03/31/2022

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 756	Continued From page 40 the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review, and review of facility documents, it was determined that the facility failed to a.) identify and clarify a pharmacy transcription error for a [redacted] medication for one resident (Resident [redacted]) and b.) identify a duplicate PRN (as needed) order for a [redacted] medication for one resident (Resident [redacted]); and c.) ensure recommendations made by the Consultant Pharmacist (CP) were acted upon or responded to in a timely manner for 3 of 5 residents (Resident [redacted] and #[redacted]) reviewed for unnecessary medications. This deficient practice was evidenced by the following: 1 (a). According to the resident's Admission Record, Resident [redacted] had diagnoses including, but not limited to, [redacted] Review of the handwritten CP recommendations dated [redacted] and [redacted] located in the chart, did not reflect that the CP identified or clarified the change in route for the PRN [redacted] (a [redacted] medication for [redacted]. The surveyor requested from the facility any recommendations from the CP and the physician's rationale. The facility failed to provide the physician's rationale and the CP recommendations for [redacted], and [redacted] of	F 756	Element #1 Resident [redacted] medication did not have a duration or stop date and frequency was transcribed as three times a day and not in hours was immediately clarified and changed according to physician and pharmacy recommendation. Care Plan updated per physician orders. Resident [redacted] medication did not have a duration or stop date and frequency was transcribed as three times a day and not in hours was immediately clarified and changed according to physician and pharmacy recommendation. Resident [redacted] had a [redacted] medication order but did not contain duration was immediately clarified and changed according to physician recommendations. Order transcription for resident [redacted] was immediately corrected to reflect administer medication [redacted]. Resident [redacted] orders transcription were immediately corrected to reflect a duration and frequency in hours on the MAR and POS. Element #2	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	315263		03/31/2022

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 756	Continued From page 41 [redacted]. Review of Resident [redacted] handwritten Physician's Orders (PO) and corresponding handwritten [redacted] Medication Administration Record (MAR) reflected an order dated [redacted] for [redacted] mg every eight hours PRN for [redacted] "[redacted]." Review of Resident [redacted]'s printed Physician's Order Forms (POF) for [redacted] and [redacted] revealed the order dated [redacted] for [redacted] mg every eight hours PRN for [redacted] was transcribed by the pharmacy as [redacted] mg one tablet "orally" every eight hours as needed for [redacted]. Review of the handwritten [redacted] Medication Administration Records (MAR) revealed Resident [redacted] received the PRN [redacted]n for [redacted] multiple" times in [redacted]. Review of the printed [redacted] MAR revealed Resident [redacted] received the PRN [redacted] for [redacted] "orally" multiple times in [redacted] Review of the printed [redacted] MAR revealed Resident [redacted] did not receive the PRN [redacted] "orally." Review of the Advanced Practice Nurse's Progress Notes dated [redacted] and [redacted] revealed "[redacted] mg PO [by mouth] q [every] 8 hours prn anxiety. Followed by [redacted]" The surveyor requested from the facility any [redacted] Evaluations completed in [redacted] or [redacted] of [redacted]. The facility failed to provide	F 756	All residents have the potential to be affected by this deficient practice. Element #3 ADON in-serviced Licensed Practical Nurse/UM#2 in-serviced on residents who receive [redacted] and are [redacted] the POS and MAR must be transcribed as frequency in hours, [redacted] and to administer [redacted] ADON in-serviced Licensed Practical Nurse/UM #3 on reviewing and completing the Pharmacy Consultant Report monthly and have the physicians sign off on it. ADON in-serviced nursing staff was in-serviced on medication transcription, including documenting administration of medication, following medication administration precautions, and updating and documenting MD orders. Element #4 Pharmacy consultant/designee to complete chart audits monthly. Findings will be reported to UM monthly. DON/designee to review Monthly pharmacy consultant reports for completion, monthly x6 with findings reported quarterly to the Quality Assurance performance Improvement committee for review and action as appropriate.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	315263		03/31/2022

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 756	Continued From page 42 further information. During an interview with the surveyor on 03/22/22 at 12:15 PM, the Licensed Practical Nurse/UM #2 (LPN/UM) reviewed the [redacted] and [redacted] physician orders and corresponding MARs with the surveyor. The LPN/UM #2 confirmed that Resident [redacted] received [redacted] and the [redacted] and [redacted] POFs and corresponding MARs reflected the medication was to be administered "orally." The LPN/UM #2 stated that the order should have been clarified. During an interview with the surveyors on 03/24/22 at 8:50 AM, the Director of Nursing (DON) and the surveyors reviewed the [redacted] physician orders, together with the corresponding MARS. The DON confirmed that the [redacted] PRN [redacted] order should have been administered through the resident's [redacted]. The DON confirmed that the nurse should have clarified the order. 2. Review of the printed [redacted] POF, signed by the physician, reflected that Resident [redacted] had a [redacted]) order dated [redacted] and further reflected an order dated [redacted] for [redacted] Tab [redacted] mg one tablet orally every 8 hours as needed for [redacted] The printed [redacted] POF did not include an order that [redacted] could be crushed and administered via Resident [redacted] Review of the handwritten readmission [redacted] PO, signed by the physician, reflected an undated order for [redacted] mg administer one tablet [redacted] three times	F 756		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	315263		03/31/2022

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 756	Continued From page 43 daily as needed for [redacted] Review of the printed and handwritten [redacted] MAR reflected two orders for PRN [redacted] as follows: A printed order dated [redacted] for [redacted] mg one tablet orally every 8 hours as needed for [redacted] and a handwritten, undated order for [redacted] mg tablet [redacted] one tablet [redacted] three times daily PRN for [redacted]. The surveyor observed that the undated order for [redacted] included [redacted]," a transcription addition not included in the [redacted] PO. The surveyor further observed that the two PRN orders for [redacted] were ordered in two different forms (regular and Orally Disintegrating Tablet (ODT)) with the same dosage of [redacted] mg. Review of the printed [redacted] POF, signed by the physician, and corresponding printed [redacted] MAR reflected an order dated 08/11/21 for [redacted] mg for [redacted] one tablet [redacted] three times daily as needed for [redacted]. The surveyor observed the [redacted] was not administered to Resident [redacted] Review of the handwritten readmission [redacted] PO, signed by the physician, reflected a handwritten, undated order for [redacted] mg tablet [redacted] PRN three times daily for [redacted] Further review of the handwritten [redacted] PO reflected an order clarification dated [redacted] to Give [redacted] mg TID [three times daily] PRN [redacted] The surveyor observed the order clarification did not discontinue the [redacted] order. The surveyor	F 756		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	315263		03/31/2022

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 756	Continued From page 44 further observed that the two PRN orders for [redacted], were ordered in two different forms (regular and [redacted]) with the same dosage of [redacted] mg continued for Resident [redacted] Review of the printed [redacted] POF, signed by the physician, reflected the order dated [redacted] for [redacted] mg for [redacted] one tablet [redacted] three times daily as needed for [redacted] The surveyor observed that the printed [redacted] order had a handwritten notation of "D/C [discontinue]" written on the printed order. The surveyor further observed a handwritten, undated order on the [redacted] POF which reflected [redacted] mg one tablet via [redacted] TID [three times daily] Dx [diagnosis] [redacted]. The surveyor observed the handwritten order did not include the notation of "PRN" or "as needed." Further, the [redacted] POF did not reflect that the discontinuation of the [redacted] order and the handwritten [redacted] order were "noted and faxed" to the pharmacy. Further review of the handwritten [redacted] PO did not reflect the discontinuation of the [redacted] order or the undated [redacted] order. Review of the printed [redacted] MAR reflected that the [redacted] mg order dated [redacted] was "yellowed" out meaning that the order was discontinued. The handwritten [redacted] MAR further reflected that the undated [redacted] mg order was transcribed as [redacted] mg one tab [redacted] PRN TID [three times daily] and was administered multiple times. The surveyor further observed the two PRN orders for [redacted], were ordered in two different forms ([redacted] with the same	F 756		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	315263		03/31/2022

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 756	Continued From page 45 dosage of [redacted] mg continued for Resident [redacted]. Review of the Advanced Practice Nurse's Progress Notes dated [redacted] and [redacted] revealed [redacted] mg PO [by mouth] q [every] 8 hours prn [redacted] Followed by [redacted]]." The Advanced Practice Nurse's Progress Notes did not reflect that Resident [redacted] was ordered duplicate PRN [redacted] orders. The surveyor requested from the facility any Psychiatrist Evaluations completed in [redacted], [redacted]. The facility failed to provide further information. During an interview with the surveyor on 03/22/22 at 12:15 AM, the LPN/UM #2 confirmed that the original [redacted] t order for [redacted] did not contain the medication form of [redacted] and stated that she was not sure why the nurse included [redacted]" when the order was transcribed to the [redacted] MAR. The LPN/UM #2 stated that the nurse should have called the physician and clarified the order. During an interview with the surveyor on 03/24/22 at 08:50 AM, the DON stated that she could not explain why the nurse transcribed the order on the [redacted] MAR as [redacted] have been clarified. The DON confirmed that there were two PRN orders for [redacted] mg from [redacted] through [redacted] for Resident [redacted] At that time, the DON stated she would investigate the reason why there were duplicate orders for the PRN [redacted] During a follow-up interview with the surveyor on 03/25/22 at 1:47 PM during Exit Conference, the DON stated that she talked to the pharmacist	F 756		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	315263		03/31/2022

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 756	Continued From page 46 who stated the preferred usage was [redacted] for [redacted] administration. The DON further stated that the nurse should dilute the [redacted] tablet with water and should not crush the medication. The surveyor inquired, "With how much water?" The DON replied, "I don't know." During a telephone interview with the surveyor on 03/28/22 at 9:50 AM, the facility's pharmacist confirmed that you cannot crush [redacted] regular or [redacted] The pharmacist further stated that [redacted] is an "orally disintegrating tablet." The directions for [redacted] reflect that you place the medication on the tongue where it will quickly dissolve. You can then swallow it with saliva or water. The directions reflect that you can swallow the dissolved medication with water but do not indicate the volume of water to use. The pharmacist stated that Resident [redacted] medication was not covered by the resident's insurance, and the medication was last dispensed on [redacted]. During a telephone interview with the surveyor on 03/28/22 at 10:08 AM, the physician's Advanced Practice Nurse stated that he is not sure why there were duplicate orders for PRN [redacted] He stated that he thought the [redacted] could be crushed and administered through the [redacted] The Advanced Practice Nurse stated he would review the duplicate orders and indicated that "we will have to change the order and put the resident on something else." During a follow up telephone interview on 03/28/22 at 10:23 AM with the DON, in the presence of the Administrator, the DON confirmed there were two PRN [redacted] orders	F 756		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	315263		03/31/2022

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 756	Continued From page 47 and the orders should have been clarified. The CP joined the interview at 10:32 AM. The CP stated that regular [redacted] cannot be crushed and indicated that you would need an order from the physician to crush the medication. The CP confirmed that the order says to administer the medication [redacted] but it does not say that it can be crushed. The CP indicated that [redacted] needed to be dissolved in 5-10 cc of water and then the medication can be administered through the [redacted] The CP stated that she is not sure why there would be two orders for PRN [redacted] with the same dose in two different forms. The CP stated, "I should have questioned the two orders." The DON further stated that this could cause confusion for the nurses as to which PRN medication to administer. The surveyor asked the facility for supporting documentation that [redacted] could be dissolved in 5-10 cc of water. The facility failed to provide further information. 3 a.) Review of the handwritten [redacted] CP recommendation, located in the chart, revealed "PRN [redacted] require duration [length of time that the PRN medication may be administered]." The surveyor requested from the facility any recommendations from the CP and the physician's rationale. The facility failed to provide the physician's rationale and the CP recommendations for [redacted] and [redacted]. Review of Resident [redacted] handwritten PO, signed by the physician, and the corresponding [redacted] MAR reflected an order	F 756		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	315263		03/31/2022

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 756	Continued From page 48 dated [redacted] for [redacted] mg every eight hours PRN for [redacted] "[redacted]." Review of the printed POF for [redacted] and [redacted] revealed the order dated [redacted] for [redacted] mg every eight hours PRN for [redacted]" was transcribed as [redacted] mg one tablet "orally" every eight hours as needed for [redacted] The surveyor observed the handwritten [redacted] PO and the printed [redacted] [redacted] POFs did not reflect a duration. Review of the June 2021 and July 2021 MARs revealed Resident #88 received the PRN Klonopin for agitation multiple times. Review of the Advanced Practice Nurse's Progress Notes dated [redacted] and [redacted] revealed [redacted] mg PO [by mouth] q [every] 8 hours prn [redacted] Followed by [redacted] [redacted]" The Advanced Practice Nurse's Progress Notes did not address the [redacted] CP recommendation. Review of the Interdisciplinary Progress Notes for [redacted] and [redacted] did not address the [redacted] CP recommendation. 3 b.) Review of the handwritten [redacted] and [redacted] CP recommendations, located in the chart, revealed "PRN [redacted] freq. [frequency] in hrs [hours]. Review of the handwritten readmission [redacted] PO, signed by the physician, and the [redacted] MAR reflected a	F 756		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	315263		03/31/2022

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 756	Continued From page 49 handwritten, undated order for [redacted] mg administer one tablet [redacted] three times daily as needed for [redacted] Review of the handwritten readmission [redacted] PO, signed by the physician, and the [redacted] MAR reflected a handwritten, undated order for [redacted] mg tablet [redacted] PRN three times daily for [redacted] Review of the handwritten [redacted] MAR further reflected that the PRN [redacted] mg one tab [redacted] PRN TID [three times daily] order continued without a frequency in hours and was administered multiple times. The surveyor observed the handwritten readmission [redacted] PO, the [redacted] PO did not reflect a duration or a frequency in hours to administer the PRN [redacted]. Review of the Advanced Practice Nurse's Progress Notes dated [redacted] and [redacted] revealed [redacted] mg PO [by mouth] q [every] 8 hours prn [redacted] Followed by [redacted]]." The Advanced Practice Nurse's Progress Notes did not address the [redacted] and [redacted] CP recommendations. Review of the Interdisciplinary Progress Notes for [redacted] through [redacted] did not address the [redacted] and [redacted] CP recommendations. During an interview with the surveyor on 03/22/22 at 12:15 PM, the Licensed Practical Nurse/UM #2 (LPN/UM) stated that the CP comes in monthly to review each resident's physician orders, MARS	F 756		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	315263		03/31/2022

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 756	Continued From page 50 and Treatment Administration Records. The CP will send his report to the DON and she will distribute the reports to the UMs to complete. There are some recommendations that the nurses can handle; and if the CP recommendation requires the physician to sign in agreement or disagreement, the LPN/UM will make a copy of the CP form placing it in the physician's box for their review. When the physician comes into the facility, she will ask the physician to review the CP recommendation forms. The physician will review the CP recommendation form, return it if approved with new orders or disapproved with a reason why. Sometimes the physician will request that the resident is to be seen by the psychiatrist. The process takes about 3-4 days or up to one week if waiting for the physician [redacted] to review the CP recommendation forms. The surveyor and LPN/UM #2 reviewed the June through [redacted] physician orders and corresponding MARs with the surveyor. LPN/UM #2 confirmed that the June through [redacted] PRN [redacted] orders did not contain a duration and the [redacted] and [redacted] PRN [redacted] orders did not reflect a frequency in hours to administer the medication. She stated that [redacted] PRN Klonopin order should have been written for 14 days, re-evaluated by the physician, and then the physician may reorder the medication for a longer duration. The LPN/UM #2 further confirmed that Resident [redacted] was [redacted] and that the [redacted] and [redacted] POFs and corresponding MARs reflected the medication was to be administered "orally." The LPN/UM #2 stated that the order should have been clarified. During an interview with the surveyor on 03/23/22 at 8:55 AM, the DON stated that the CP reviewed	F 756		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	315263		03/31/2022

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 756	Continued From page 51 each resident's medications monthly and faxed or emailed the report to her. The DON stated that she then disbursed the recommendations to the Unit Managers to complete this process within a week or so. The DON stated that the Unit Manager was responsible to complete the CP recommendations. During a follow-up interview with the surveyors on 03/24/22 at 8:50 AM, the DON and the surveyors reviewed the [redacted] and [redacted] physician orders, together with the corresponding MARS. The DON confirmed that the [redacted] PRN [redacted] order required a duration and should have been administered through the resident's [redacted] The DON confirmed that the nurse should have clarified the order. She stated that the original [redacted] PRN [redacted] order should have been written with a duration of 14 days, the physician then re-evaluates the medication; and at that time, the physician may reorder the medication for a longer duration. The DON further confirmed that the [redacted] t, [redacted] and [redacted] PRN [redacted] orders should not have been written TID or 3x daily. The DON further stated to prevent confusion, the orders should be written every eight hours, and the DON expected the nurse to clarify the orders. 3 c.). According to the Resident Face Sheet, Resident [redacted] was admitted to the facility with diagnoses which included, but were not limited to, [redacted],	F 756		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	315263		03/31/2022

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 756	Continued From page 52 [redacted]). Review of the Quarterly Minimum Data Set (MDS), an assessment tool utilized to facilitate the management of care, dated [redacted], revealed that Resident [redacted] had a Brief Interview for Mental Status score of [redacted] indicating the resident was [redacted] The MDS further revealed in [redacted] that Resident [redacted] had a current diagnosis of [redacted] and Section [redacted] revealed Resident [redacted] had received [redacted] medications on 3 out of 7 days during the look back period. Review of the [redacted] CP recommendation located in the chart revealed a recommendation to address the duration on PRN [redacted]. On [redacted] the CP recommended to clarify the PRN [redacted]. The surveyor requested from the facility any recommendations from the CP and the physician's rationale. The facility provided two written recommendations dated [redacted] and [redacted]. The surveyor reviewed a CP recommendation dated [redacted] which included "A duration must be specified for PRN psychoactive medications. First order is limited to only 14 days, but if rationale documented by prescriber to continue order, then the next duration may be longer, i.e., 30, 60, 90 days. Please update order for [redacted] per CMS regulations." Review of the CP recommendation dated [redacted] included "A duration must be specified for PRN [redacted] medications. First order is limited to only 14 days, but if rationale	F 756		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	315263		03/31/2022

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 756	Continued From page 53 documented by prescriber to continue order, then the next duration may be longer, i.e., 30, 60, 90 days. Please update order for [redacted] per CMS regulations." The physician did sign this recommendation, dated [redacted], to renew for 90 days, but a physician's order was not initiated. Review of Resident [redacted] POF dated [redacted] and [redacted], included an order for [redacted] mg one tablet orally every six hours as needed for [redacted] with an order date of [redacted]. Further review of the order revealed the order did not contain a duration. Review of the MAR dated [redacted] and [redacted] did not contain a duration for the [redacted] mg order and the medication was administered multiple times. Review of Resident [redacted] POFs dated [redacted], [redacted], [redacted], and [redacted], included an order for [redacted] mg one tablet orally every 12 hours as needed for [redacted] with an order date of 0[redacted]. Further review of the order revealed the order did not contain a duration. Review of the MARs dated [redacted], [redacted] and [redacted]r [redacted] did not contain a duration for the [redacted] mg order and the medication was administered multiple times. Review of Resident [redacted]s POF dated [redacted] and [redacted] included an order for [redacted] mg one tablet orally every 12 hours as needed for [redacted] with an order date of [redacted]. Further review of the order revealed the order did not contain a duration.	F 756		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	315263		03/31/2022

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 756	Continued From page 54 Review of the MAR dated [redacted] and [redacted] did not contain a duration for the [redacted] mg order and the medication was administered multiple times. Review of the Physician's and Advanced Practice Nurse's progress notes dated [redacted] through [redacted] did not include a rationale or indicate the duration for the PRN [redacted] During an interview with the surveyor on 03/22/22 at 1:40 PM, Licensed Practical Nurse/Unit Manager #3 (LPN/UM) stated that the CP comes into the facility monthly and sends the facility a report. LPN/UM #3 further stated, "I try to act on the report as soon as possible and will alert the doctors as soon as possible." During an interview with the surveyor on 03/24/22 at 11:38 AM, the Director of Nursing (DON) stated that the CP would send the recommendations to the DON. The DON will then give the recommendations to the UM to review the pharmacy recommendations and call the doctor for any orders related to the recommended changes. The UM will then write a telephone physician order in the chart and the physician will then sign it. 3 d.). According to the Resident Face Sheet, Resident [redacted] was admitted to the facility with diagnoses which included, but were not limited to, [redacted]). Review of the [redacted] CP recommendation,	F 756		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	315263		03/31/2022

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 756	Continued From page 55 located in the chart, revealed a recommendation to address the duration on PRN [redacted] The surveyor requested from the facility any recommendation from the CP and the physician's rationale. The facility failed to provide any further information. Review of Resident [redacted]s printed POF dated [redacted] and [redacted] included [redacted] milligram (mg) 1 tablet orally every 8 hours as needed for [redacted] with an order date of [redacted]. Further review of the order revealed the order did not contain a duration. Review of the Medication Administration Records (MAR) dated [redacted], and [redacted] did not contain a duration order for [redacted] mg and the medication was administered multiple times. Review of Resident [redacted] printed POF dated [redacted] and [redacted] included an order for [redacted] mg orally every 6 hours as needed for [redacted] dated [redacted]. Further review of the order revealed the order did not contain a duration order. Review of the MAR dated [redacted], [redacted] and [redacted] did not contain a duration order for [redacted] mg and the medication was administered multiple times. Review of the physician's progress notes dated [redacted] through [redacted] did not include a rationale or indicate the duration of use for the PRN [redacted]	F 756		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	315263		03/31/2022

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 756	Continued From page 56 Review of the facility's Use of [redacted] Drugs policy, revised 01/31/22, reflected "PRN orders for [redacted] drugs are limited to 14 days, except as provided if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days. He or she should document their rationale in the resident's medical record and indicate the duration for the PRN order." The policy further reflected that a "Resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: ...b. For excessive duration." Review of the facility's Medication Regimen Review (MRR), revised 02/01/22, reflected "Each residents' drug regimen remains free of unnecessary drugs. An unnecessary drug is any drug when used: a. In excessive doses, including duplicate therapy. b. For excessive duration." NJAC 8:39 - 29.3	F 756		
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic	F 758		5/5/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	315263		03/31/2022

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 758	Continued From page 57 Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of other facility documentation, it was determined	F 758	Element 1	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	315263		03/31/2022

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 758	Continued From page 58 that the facility failed to a.) administer an as-needed (PRN) [redacted] medication in accordance with the physician's orders for one resident and b.) ensure that a PRN psychotropic medication was administered for no more than 14 days without further evaluation with corresponding documentation for one resident. This deficient practice was identified for 2 of 5 residents (Residents [redacted] reviewed for unnecessary medications and was evidenced by the following: 1. According to the resident's Admission Record, Resident [redacted] had diagnoses including, but not limited to, [redacted] Review of the handwritten [redacted] Physician's Orders (PO) revealed that Resident [redacted] had an undated order for [redacted] (an [redacted] medication) [redacted] mg tablet [redacted] PRN (as needed) three times a day for [redacted] A review of the handwritten [redacted] Medication Administration Record (MAR) revealed that the ordered medication was plotted to be administered by the nursing staff at 9:00 AM, 1:00 PM, and 5:00 PM. The surveyor observed that the handwritten "PRN" in the order had a single line crossed through it. The MAR reflected that [redacted] mg was administered three times daily on 09/15/21, 09/16/21, 09/17/21, and 09/18/21. The [redacted] MAR further reflected the medication was administered at 9:00 AM on 09/19/21.	F 758	MD was immediately made aware of the medication orders for residents # [redacted] and [redacted] [redacted] evaluation done on both residents. Resident [redacted] order was Discontinued by [redacted] and MD on 3/29/22. Resident [redacted] order will be updated by MD as needed Residents with PRN (as needed) orders were checked immediately to ensure that they are written in hours and not specific time a day. Element 2 All residents have the potential to be affected by this deficient practice. Element 3 Unit Managers and Nurses were in-serviced by the ADON on the procedure to follow when obtaining, transcribing, and following-up on a [redacted] medication for duration and MD/NP to reevaluate after 14 days. ADON Unit Managers and Nurses were in-serviced on differentiating between how PRN medication orders and standing medication orders should be transcribed on the MARs and TARs (frequency in hours). Element 4 UM/designee to check 2 charts (orders) of residents currently on [redacted] weekly x 4 and monthly x4 with findings reported quarterly to the Quality	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	315263		03/31/2022

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 758	Continued From page 59 During an interview with the surveyor on 03/22/22 at 12:15 PM, the Licensed Practical Nurse/Unit Manager #2 (LPN/UM) reviewed the handwritten [redacted] PO and [redacted] MAR for Resident [redacted]. The LPN/UM #2 confirmed that the order was a PRN order and that the order was administered as plotted on the MAR at 9:00 AM, 1:00 PM and 5:00 PM. The LPN/UM #2 could not explain why the MAR reflected the plotted times of 9:00 AM, 1:00 PM and 5:00 PM and stated that this was a transcription error and should have been caught by the nurse during the nightly chart check. During an interview with the surveyor on 03/24/22 at 8:50 AM, the Director of Nursing stated that the order should have been written in frequency of hours not three times daily. The DON confirmed that the [redacted] MAR reflected that the PRN [redacted] order was plotted at 9:00 AM, 1:00 PM and 5:00 PM and was signed by the nurses as administered. 2. According to the Resident Face Sheet, Resident [redacted] was admitted to the facility with diagnoses which included, but were not limited to, [redacted]). Review of the Quarterly MDS, dated [redacted] revealed that Resident [redacted] had a Brief Interview for Mental Status score of [redacted] indicating the resident was [redacted]. The MDS reflected in Section I that Resident [redacted] had a current diagnosis of [redacted] and Section [redacted] revealed Resident [redacted] had received [redacted] medications on 3 out of 7 days during the look	F 758	Assurance performance Improvement committee for review and action as appropriate	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	315263		03/31/2022

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 758	Continued From page 60 back period. Review of Resident [redacted] verbal telephone PO revealed an order dated [redacted] for [redacted] mg po (by mouth) every 12 hours PRN times 14 days for diagnosis of a [redacted]. Review of the Resident [redacted] Physician Order Form (POF) revealed an order for [redacted] mg 1 tablet orally every 12 hours (Give with 1 mg for total dose of 1.5 mg) as needed for 14 days with a discontinued date of [redacted]. The [redacted] POF further revealed an order for [redacted] mg tablet orally every 12 hours (Give with [redacted] mg for a total dose [redacted] mg) as needed for 14 days with a discontinued date of [redacted] Review of Resident # [redacted] MAR reflected that the [redacted] mg order dated [redacted] was signed as administered three times after 03/10/22 on 03/16/22, 03/17/22 and 03/20/22. During an interview with the surveyor on 03/24/22 at 11:38 AM, the DON stated that new orders for [redacted] medications would be ordered for 14 days then the doctor would reevaluate the resident and reorder the medication if needed. The DON stated that the nurse should not have given the [redacted] after the 14 days. The DON further stated that she would expect the nurse would call the doctor to get a new order for [redacted] prior to administering the medication after the 14 days and the doctor should have reevaluated the resident. Review of the facility's policy titled "Use of [redacted] Drugs," revised 01/21/2022, reflected that PRN orders for [redacted] drugs	F 758		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	315263		03/31/2022

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 758	Continued From page 61 are limited to 14 days, except as provided if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. PRN orders for [redacted] drugs are limited to 14 days and cannot be renewed unless the attending physicians or prescribing practitioner evaluates the resident for the appropriateness of that medication." Review of the facility's undated policy titled "Physician Medication Orders" reflected that one day prior to the date the stop order is to become effective, the nurse/supervisor charge nurse on duty must contact the attending physician to determine if the medication is to be continued. Review of the facility's Medication Orders policy, dated 02/01/22, reflected "PRN Medication Orders - When recording PRN medication orders, specify: a. The type, route, dosage, frequency, strength and the reason for administration (i.e., Tylenol 500 mg p.o. [by mouth] q4h [every 4 hours] mild pain or temp [temperature] > 101 degrees F [Fahrenheit])." Review of the facility's Medication Regimen Review policy, revised 02/01/22, reflected that "Each residents' drug regimen remains free of unnecessary drugs. An unnecessary drug is any drug when used: a. In excessive doses, including duplicate therapy." N.J.A.C. 8:39-27.1(a), 29.2 (d), 29.3 (a)(4)	F 758		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)	F 761		5/5/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	315263		03/31/2022

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 761	Continued From page 62 §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 by: Based on observation, interview, and review of facility documentation, it was determined that the facility failed to properly store refrigerated medications. This deficient practice was identified for 1 of 2 medication refrigerators inspected, on 1 of 2 units [redacted]-Wing unit) reviewed for medication storage and labeling and was evidenced by the following: On 03/23/22 at 01:40 PM, the surveyor inspected the [redacted]-Wing unit medication refrigerator, in the	F 761	Element 1 Facility change the thermometer out and temperature of refrigerator read correctly within acceptable range. LPN/UM #2 immediately removed all medications that were in the refrigerator with the temperature reading 24 degrees F. LPN/UM #2 immediately reordered all the medications that were removed from the refrigerator.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	315263		03/31/2022

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 761	Continued From page 63 presence of the Licensed Practical Nurse Unit Manager #2 (LPN/UM). The surveyor observed the refrigerator temperature to be 24 degrees Fahrenheit (F), a temperature that is below the freezing point of 32 degrees F. The surveyor observed the following medications inside the refrigerator: one [redacted] milliliter (ml) [redacted] (used to treat [redacted]), one [redacted]/ml solution vial (used to treat [redacted]), one [redacted] units/ml vial (used to treat [redacted], and one 120 (ml) bottle of [redacted] solution [redacted] (used to treat [redacted] When interviewed at that time, the LPN/UM #2 stated that the temperature of the refrigerator should be between 36 and 46 degrees F. The LPN/UM #2 further stated that if the temperature was not in the temperature range, the medication would not be good and the medication would have to be reordered. The surveyor reviewed the temperature log with the LPN/UM #2 and observed that today's temperature was blank. The LPN/UM #2 confirmed that the temperature was not recorded for 03/23/22 and stated that the 11-7 shift nurse is responsible to check the temperature and record it on the log daily. During an interview with the surveyor on 03/23/2022 at 01:40 PM, the 11-7 shift Licensed Practical Nurse #2 on the unit, stated she checked the temperature and logged it prior to leaving in the morning. She stated that today, she also worked the 7-3 shift and acknowledged that she had no excuse for why she did not check and fill out the sheet this morning. During an interview with the surveyor on 03/24/22 at 03:31 PM, the Director of Nursing (DON) stated that she expected the nurse to inform maintenance of any refrigerator issues and to	F 761	Element 2 All residents have the potential to be affected by this deficient practice. Element 3 Unit Managers and Nurses were in-serviced by ADON on checking the thermometer and filling out the temperature log daily to ensure that the refrigerator is within the range of 36- and 46-degrees F. Element 4 UM/designee to check logs weekly x 4 and monthly x4 with findings reported quarterly to the Quality Assurance performance Improvement committee for review and action as appropriate.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	315263		03/31/2022

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 761	Continued From page 64 obtain another thermometer from maintenance, to make sure that the one being used was not broken. The DON further stated she expected the nurse to remove the medication and place it in a different refrigerator. A review of the facility's policy titled, "Medication Storage," revised 10/01/2021, revealed that Section 4 addressed refrigerated products, indicating a need for temperatures to be maintained at a range of 35-45 F. The policy further reflected that charts are kept on each unit refrigerator and temperature levels are recorded daily, by the charge nurse or other designee. NJAC: 8:39-29.4 (H)	F 761		
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. (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.	F 812		5/5/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	315263		03/31/2022

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 65 This REQUIREMENT is not met as evidenced by: Based on observations, interviews and review of other facility documentation it was determined that the facility failed to a.) properly store potentially hazardous foods in a manner that is intended to prevent the spread of food borne illnesses, b.) maintain equipment and kitchen areas in a manner to prevent microbial growth and cross contamination and c.) failed to maintain adequate infection control practices in the kitchen. This deficient practice was identified and evidenced by the following: On 03/17/22 from 09:59 AM to 11:09 AM, the surveyor toured the kitchen in the presence of the Food Services Director (FSD) and observed the following: 1. The FSD wore a hairnet on the back of her head with the front left side and the front right side of her hair exposed. The FSD acknowledged that her hairnet fell off and that hairnets were to be worn at all times in the kitchen. The FSD stated it was important to wear hairnets correctly so no hair got into the resident's food. 2. In the walk-in refrigerator on a metal rack were two trays of individually wrapped sandwiches, that the FSD identified as peanut butter and jelly, with no labels and no dates. There were four trays of individual cups, that the FSD identified as pears, with no labels and no dates. There was one tray of individual cups, that the FSD identified as vanilla pudding, with no labels and no dates. There was one tray of individual cups, that the FSD identified as chocolate pudding, with no	F 812	Element One - Corrective Action The observed issues were corrected as follows: 1. FSD adjusted her hairnet, so all hair was completely covered 2. In the walk-in refrigerator on a metal rack " two trays of individually wrapped sandwiches were identified as peanut butter and jelly, was discarded. " The four trays of individual cups of pears were discarded " The one tray of individual cups vanilla pudding was discarded. " The one tray of individual cups chocolate pudding was discarded. 3. The unlabeled and undated meat and chicken were discarded immediately by FSD. 4. The 2 bags identified as flour and sugar were discarded immediately 5. The slicer was cleaned immediately 6. The pans where correctly placed for drying 7. The Cook applied a beard net	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	315263		03/31/2022

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 66 labels and no dates. The FSD acknowledged there were no labels nor dates on the food items and stated that it was important to label and date the food as soon as they were prepared to prevent illness. 3. In the walk-in freezer on a sheet pan resting on a metal rack was one frozen package of pink meat, that the FSD identified as ground pork, with no label and no date. On the same metal rack were four individually wrapped frozen chickens that were each labeled young chicken, with no dates. The FSD acknowledged that there were no dates, labels on the identified meats and stated that all the meat should have been dated and labeled so that it was known that the meat was still fresh. The FSD removed the pork and the chickens from the freezer. 4. In the food prep area on the bottom shelf of a metal table was one bin that held an opened, brown paper bag that contained a white substance, that the FSD identified as sugar, inside of an opened clear plastic bag, with no label and no dates. Resting on the shelf there was an opened, brown paper bag that contained a white substance, that the FSD identified as flour, inside of an opened clear plastic bag, with no label and no dates. The FSD acknowledged the flour should have been in a bin and discarded the bag of flour. 5. In the food prep area on a metal table was an uncovered meat slicer. There was pink debris on the base of the slicer and the cook stated the slicer was last used two days prior then was cleaned and sanitized. The FSD acknowledged the debris should not be there and stated that it was important to keep the slicer clean to prevent	F 812	immediately 8. The dented cans where immediately discarded 9. The Spaghetti was discarded immediately 10. The Dish washer staff appied beard mask immediately An in-Service on the policy of the facility that hairnets and beard nets for restraining all hair must be worn by any person entering the kitchen was conducted for dietary department employees. Dietary staff received re-education regarding proper storage and dating & labeling of food, and kitchen sanitation. The food service director also conducted re-education regarding proper cleaning of the slicer, All areas where refrigerated foods and dry foods were stored were checked to ensure that they were dated and discarded by their "use by" date. Element Two All residents have the potential to be affected by these practices.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	315263		03/31/2022

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 67 food contamination. 6. On the metal drying rack were 7 six inch pans that were wet nested. The FSD acknowledged the wet nesting and stated the pans should be tilted to dry and not stacked. 7. On 03/17/22 at 10:37 AM, the surveyor observed the cook in the galley at the hot food prep table wearing a surgical mask with facial hair visible around the surgical mask. The cook acknowledged he was not wearing a beard cover and stated he should have been wearing a beard cover to prevent hair from contaminating the food. 8. In the dry storage room, there was one dented 6 pound can of tomatoes and one dented 6 pound 10 ounce can of pear slices. The FSD acknowledged the dented cans and stated that they should have been in the dented can section. The FSD further stated it was important to prevent illness by not using dented cans and removed the cans from the shelf. 9. There was one large, opened package of spaghetti wrapped with yellow plastic wrap with no open or use by dates. The FSD acknowledged the spaghetti was not dated and stated that it was important to date all the food so that they knew how old the food was. 10. On 03/17/22 at 10:50 AM, the surveyor observed the dish washer stocking the freezer wearing a surgical mask with facial hair visible around the surgical mask. The dish washer acknowledged he was not wearing a beard cover and stated it was important to cover all hair so hair would not get into the food.	F 812	Element Three - Systemic Changes Food Services Director/Designee will audit staff daily for proper use of hairnet/beard covering Flour and sugar will be stored in a bin and all bins will be labeled and dated appropriately. The food service director provided re-education to dietary staff regarding the facility food storage and labeling and dating procedures. The food service director will inspect and enforce that all hair is covered with appropriate hair coverings (beard net and hair net) for all individuals entering the kitchen. The slicer will be inspected daily by the cook to ensure that it is properly cleaned. FSD or designee will inspect daily that all dry goods are properly store in the appropriate containers and dated FSD or designee will check weekly for any dented cans and remove from the area Element Four - Quality Assurance The FSD will conduct weekly inspections of the kitchen to assure compliance with	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	315263		03/31/2022

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 68 Review of the facility policy, "Hairnet Restraints," dated 8/7/2018, revealed Policy: Hairnets must be worn by anyone who enters the kitchen to prevent hair from contaminating food and or equipment. Procedure: 3. All hair must be contained inside the hairnet. Review of the undated facility policy, "Food Storage Procedure," revealed 5. All foods stored in the refrigerator or freezer will be covered, labeled and dated. Review of the facility policy, "Dry Food Storage," dated 8/18/2015, revealed Procedure: 4.) Food is dated as it is placed on the shelves. 6.) Broken lots of bulk food will be stored in plastic containers with tight fitting lids, accurately labeled & dated. Review of the facility policy, "Dishroom," dated 7/22/2021, revealed 8. Allow the dishes to air dry on the dish racks. Review of the facility policy, "Dented Cans," with a revision date of 7/22/2021, revealed Procedure: 1. When cases of canned goods are opened, all cans will be checked to make sure they are free of dents, bulges or leaks. 2. If found, it will be dated and an arrow drawn on the top pointing to the dent. 3. The dented cans will be taken downstairs to the area designated for dented cans. Review of the undated facility policy, "Equipment Cleaning," revealed Procedures: Meat and Food Slicers 5) Clean shafts and all parts under the frame. 7) Clean the stationery parts in place.	F 812	all food storage, labeling and dating, use of equipment and removal of dented cans. Continue monitoring for use of proper head and beard covering. The FSD will provide a copy of the weekly inspections to the 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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	315263		03/31/2022

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 69 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 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	F 880		5/5/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	315263		03/31/2022

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 880	Continued From page 70 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, record review and review of other facility documentation, it was determined that the facility failed to a.) follow isolation protocols for newly admitted residents who required transmission-based precautions for 14 days to monitor for signs and symptoms as Persons Under Investigation (PUI) for COVID-19 b.) ensure that staff donned Personal Protective	F 880	Element 1 Facility perform a Root cause analysis and it was determine that a)one staff member did not redirect the resident to the room because so she did not want the surveyor to view it as abuse	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	315263		03/31/2022

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 880	Continued From page 71 Equipment (PPE) in the proper sequence to provide maximum protection to both the wearer and resident c.) ensure that staff wore appropriate PPE when they entered the room of a resident who was on transmission-based precautions/PUI, d.) ensure staff performed hand hygiene before and after they entered resident rooms who were on transmission-based precautions/PUI, and e.) establish a clean field and consistently use proper hand hygiene during a wound treatment. This deficient practice was identified for 1 of 4 residents (Resident [redacted]) reviewed for transmission-based precautions and 1 of 2 residents (Resident [redacted] reviewed for pressure ulcer and was evidenced by: 1. During the entrance conference with the Administrator and the Director of Nursing (DON) on 03/17/22 at 09:43 AM, the DON stated that there were no positive cases of COVID-19 at the facility and that the required PPE to be donned for PUI rooms on the [redacted]-Wing unit included an N-95 mask (filtering facepiece respirator that filters at least 95% of airborne particles), goggles or face shield, gown, and gloves. The DON further stated that the required PPE should be donned prior to entering the PUI room. The DON further stated that in the hallways of the C-Wing unit, the required PPE was a surgical mask. During the initial tour of the facility on 03/17/22 at 11:02 AM, the surveyor observed signage that was hung outside of Resident #[redacted]s room that cautioned: Yellow Zone to enter resident rooms staff must have: N-95 Mask, Face Shield/Goggles, Gown and Gloves. At that time, the surveyor interviewed a Housekeeper that was	F 880	b) Staff was aware of proper use of PPE but chose to wear it inappropriately c) Unit Manager was not aware that she could correct staff in front of surveyor d) Temporary nursing assistance knew proper PPE use but forgot he was entering a PUI room e) Nurse admitted she failed to follow proper wound care procedure . All staff was educated to attempt to re-direct residents who are required to remain in the PUI area for the duration of quarantine. All staff was educated on proper PPE to DON in each zone; red, yellow, or green. Resident [redacted] was care planned for non-compliance of infection control procedures. All TNA□s will be educated and evaluated by administrative nursing staff. Element 2 All residents have the potential to be affected by these deficient practices. Element 3 IP will in-service all staff on the expectations of residents in the PUI section of the facility, and on re-directing residents when they attempt to leave the PUI area. Educational counseling for CNA #2 ultimately resulting in termination.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	315263		03/31/2022

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 880	Continued From page 72 present outside of the room. The Housekeeper stated that the residents in the room were new admissions and may or may not have COVID-19, so full PPE was required to enter the room. The surveyor then interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM) #3 immediately after she exited the resident's room. LPN/UM #3 stated that the residents who resided in the room were recently admitted to the facility and full PPE was required to enter the room as the residents remained under observation to rule out COVID-19. She further stated that she doffed (removed) her PPE and disposed of it within a trash receptacle within the resident's room before she exited, and the PPE included an N-95 mask with a surgical mask over top, gown, gloves and goggles or face shield. LPN/UM #3 also stated that she performed hand hygiene and donned gloves before she cleaned her goggles with disinfectant wipes after she left the room. The surveyor observed LPN/UM #3 as she doffed her gloves and performed hand hygiene with alcohol-based hand rub that was readily available outside of the room. On 03/17/22 at 11:12 AM, the surveyor observed Resident [redacted] lying in bed watching television accompanied by two roommates (Residents [redacted] and [redacted]). Resident [redacted] stated that he/she was recently admitted to the facility for rehabilitation and was tested for COVID-19 twice per week. At 12:11 PM, the surveyor observed Resident [redacted], who was not wearing a face mask, self-propel his/her wheelchair down the hall and into the dining room. Certified Nursing Assistant (CNA) #1 greeted the resident as he/she passed the nurse's station and did not remind the resident that a mask was required to be worn in	F 880	IP will in-service Unit Managers on proper ways to educate staff when a breech in infection control procedures is noticed. IP will educate and competency all staff on proper handwashing procedures and times. TNA was educated on proper PPE to wear in a PUI area and handwashing. LPN#3 and all nurses were educated on proper wound care procedure and infection control procedures during wound care. As part of the Directive plan of correction (DPOC) all staff was in-service and watch the modules and videos as fallows Module 1 infection prevention and control Program view by: topline staff and infection preventionist videos covid -19 out view by frontline staff Clean Hands view by frontline staff PPE Correctly for Covid 19 view by frontline staff Module 5 Outbrakes view by: topline staff and infection preventionist Module 11b Enviromental Cleaning and disinfection view by view by: all staff topline staff and infection preventionist Module 7 hand Hygiene view by: all staff topline staff and infection preventionist	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	315263		03/31/2022

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 880	Continued From page 73 public areas or that the resident who was on PUI was required to remain within his/her room for 14 days while on observation for COVID-19. The resident self-propelled his/her wheelchair to the first table in the dining room that was closest to the entrance and was seated next to another resident who CNA #1 identified as Resident [redacted] The remainder of the residents were more than six feet away from Resident #[redacted] at adjacent tables. The surveyor observed CNA #1 who watched the two residents as they dined together and did not intervene. At 12:14 PM, the surveyor interviewed CNA #1 who stated that full PPE was required to go into Resident [redacted]'s room because it was considered a PUI room. At 12:41 PM, the surveyor observed Resident [redacted], who was now wearing a surgical mask, self-propel his/her wheelchair back to his/her room. During a follow-up interview with CNA #1 at 02:53 PM, she stated that she told Resident [redacted] that he/she was required to eat in his/her room and not in the dining room, but the resident had a friendship with Resident [redacted] CNA #1 further stated that since the surveyor was present in the dining room, she did not want to push the issue with Resident [redacted] and have it be perceived as abuse. CNA #1 stated that when she told the resident that he/she was required to dine in his/her room, the resident stated, "I know, but I want to eat here now." According to the Admission Record (an admission summary), Resident [redacted] was admitted to the facility with diagnosis which	F 880	Module 6a Principles of standard precautions view by: all staff topline staff and infection preventionist Module 6b Principles of transmission based precautions view by: all staff topline staff and infection preventionist Element 4 Infection Preventionist will conduct random observations on staff from all departments on proper Personal Protective equipment, Hand Hygiene.audits weekly x4, then monthly x6 and report findings to the Quality Assurance performance Improvement committee for review and action as appropriate..	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	315263		03/31/2022

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 880	Continued From page 74 included, but were not limited to, [redacted]) and [redacted]. Review of Resident [redacted] admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted], revealed that the resident had a Brief Interview for Mental Status (BIMS) score of "[redacted] which indicated that the resident was [redacted]. Further review of the MDS indicated that the resident required supervision and set up help for bed mobility, transfers and eating. Review of Resident [redacted] Care Plan that was contained within the Electronic Health Record (EHR) revealed that there was a single entry that specified the following: "Do [sic.] to COVID-19 I am mandated to wear a mask for my safety and the safety of others (Resident is [redacted]t). Resident is [redacted] with 14 day isolation for new admissions related to COVID-19." Review of the associated Goal was for the "resident to remain free from issues related to mask use and free from possible illness. (Refuse)." Interventions included: "Assess proper wear of mask, educate resident on the importance of wearing his/her mask and the importance of the 14 day isolation period, encourage resident to isolated [sic.] for 14 day period and wear mask." All portions of the Care Plan entry were dated [redacted] Review of Resident [redacted]s medical record included documented evidence that the resident had a negative [redacted] test on [redacted] and a negative [redacted] (polymerase chain reaction test, a diagnostic test that determines if a person	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	315263		03/31/2022

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 880	Continued From page 75 was infected with COVID-19 by analyzing a sample to see if it contained genetic material from the virus) on [redacted] During an interview with the surveyor on 03/17/22 at 03:03 PM, the Registered Nurse Assessment Coordinator (RNAC) stated that she confirmed that Resident [redacted] had received one dose of the COVID-19 Vaccination on [redacted] and was not yet up to date on his/her vaccinations. During an interview with the surveyor on 03/17/22 at 03:17 PM, in the presence of the survey team, the Infection Preventionist (IP) stated that new admissions who were unvaccinated were placed on PUI for 14 days. The IP further stated that all staff who entered a PUI room were required to wear full PPE. The IP also stated that the facility discouraged residents from coming out of their room during the first 14 days while on observation. The DON, who was present during the interview, stated that PUI residents were not permitted to dine in the lunchroom, but were noncompliant. The DON stated that the staff should have redirected any PUI residents, who were not masked in the lunchroom, back to their isolation room. During an interview with the surveyor on 03/21/22 at 10:18 AM, Resident [redacted] stated that upon admission to the facility, a therapist informed the resident that he/she was required to remain within the room for 14 days. The resident stated that on [redacted] he/she was upset because someone took the remote to the television, so he/she self-propelled out of his/her room down to the dining room to eat lunch and watch television there. The resident stated that he/she shared a table during lunch with Resident [redacted] Resident	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	315263		03/31/2022

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 880	Continued From page 76 [redacted] further stated that one of the nurses tried to remind him/her to remain in his/her room, but he/she was mad and forgot. The surveyor reviewed an undated facility policy titled, "Admission Protocol" which revealed "Each new admission will be required to wear a facemask upon entry to the facility and be immediately escorted to their assigned room," "All new admissions will be swabbed immediately upon admission, regardless of prior COVID testing results, and will be placed on transmission based precautions for 14 days from testing regardless of test results of the facility PCR test," and "During the 14 day period new admissions will not be allowed outside their room and no visitors will be permitted except for a compassionate care visit." 2. On 03/18/22 at 12:17 PM, the surveyor observed CNA #2 as she donned an N-95 mask over top of a surgical mask when she donned her PPE prior to delivering a lunch tray to Residents [redacted] and #[redacted], all of whom were in a PUI room. When interviewed, CNA #2 stated that she wore an N-95 mask over her surgical mask because it was easier to don it over her surgical mask, rather than taking everything off. CNA #2 further stated that she knew she was supposed to don the N-95 first and place the surgical mask over it, but that she felt that she was still protected because she could not smell anything. The CNA also stated she would change her mask in the restroom rather than in the hallway. During an interview with the surveyor on 03/18/22 at 12:35 PM, LPN/UM #3 stated that staff were required to perform hand hygiene and don their gown, N-95 respirator mask, goggles, and gloves	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	315263		03/31/2022

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 880	Continued From page 77 prior to entering a PUI room. The LPN/UM further stated that she saw CNA #2 as she donned her N-95 mask over her surgical mask but did not want to say anything to her in front of the surveyor. During an interview with the surveyor on 03/21/22 at 01:51 PM, the IP stated that if CNA #2 wore an N-95 mask over top of a surgical mask the N-95 mask would not be effective due to the improper fit and it would be a breach in infection control. The IP provided the surveyor with Employee Education Attendance Records which revealed that CNA #2 completed in-services related to Yellow Zone/Red Zone PPE usage on [redacted], and [redacted] which included proper donning/doffing of PPE. 3. On 03/21/22 at 12:24 PM, the surveyor observed a Temporary Nursing Assistant (TNA) who wore a surgical mask during the meal pass as he approached Resident [redacted]'s room with a meal tray. Resident [redacted] room was marked with signage that specified that the resident's room was in the Yellow Zone and an N-95 mask, face shield/goggles, gown and gloves were required to enter the room. The TNA did not perform hand hygiene or don any of the required PPE that was listed on the signage before he entered the room and placed Resident [redacted]'s meal tray on the over bed table. The TNA then exited the resident's room without first performing hand hygiene and began to enter the room of a resident who was not on isolation but was stopped by both LPN #6 and CNA #2 who were present during the observation. At that time, the surveyor interviewed the TNA who stated that he only went into Resident [redacted]'s room to drop off a meal tray. He further stated that he did not don a	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	315263		03/31/2022

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 880	Continued From page 78 gown, gloves, N-95 mask or goggles/face shield because he forgot that the resident's room was in the Yellow Zone and under observation for signs and symptoms of COVID-19. The TNA also stated that he was supposed to wash his hands when he left the room but had forgotten to. During an interview with the surveyor on 03/21/22 at 01:30 PM, LPN #6 stated that she observed the TNA go into the PUI room and that he should have donned an N-95 mask, goggles, gloves, and a gown before he entered the resident room for infection control purposes. During an interview with the surveyor on 03/21/22 at 01:40 PM, the IP stated that nursing was in-serviced to educate the CNAs on the spot if they saw any breach in the infection control policy. The IP further stated that during the meal pass, the TNA was required to don full PPE and that since the TNA entered a PUI room with only a surgical mask, there was a breach in the infection control policy. The IP provided the surveyor with Employee Education Attendance Records which demonstrated that the TNA completed in-services related to Yellow Zone/Red Zone which included required PPE usage, properly putting on PPE, hand washing and infection control competencies on [redacted] and [redacted]. During an interview with the surveyor on 03/21/22 at 02:07 PM, the DON stated that the TNA was required to wear full PPE when he entered the PUI room in the Yellow Zone. The DON further stated it would not be appropriate for the TNA to go into a PUI room wearing only a surgical mask because that was not the recommendation from the Center for Disease Control (CDC) or state	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	315263		03/31/2022

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 880	Continued From page 79 regulations. The surveyor reviewed the facility policies titled, Considerations for Cohorting COVID-19 Patients in Post-Acute Care Facilities, dated 02/25/22, Handwashing/Hand Hygiene, revised 08/15/21, and Transmission-Based Precautions, revised 08/01/22, which revealed the following: "New or readmitted asymptomatic patients/residents who are note up to date with all recommended COVID-19 vaccine doses and have a viral test negative for SARS-CoV-2 Upon admission or readmission: These patients/residents should be placed in quarantine and cared for using full PPE (gowns, gloves, eye protection, that covers the front and sides of face, and NIOSH (National Institute for Occupational Safety and Health) approved N-95 or equivalent or higher-level respirator), even if they have a negative test upon admission. Testing is recommended immediately (upon admission) and, if negative, again 5-7 days after their admission. Quarantine may be discontinued after day 7 if a viral test is negative for SARS-CoV2 and they do not develop symptoms. The specimen should be collected and tested within 48 hours before the time of planned discontinuation of quarantine." "This facility considers hand hygiene the primary means to prevent the spread of infections." "All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors." "Employees must wash their hands for at least	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	315263		03/31/2022

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 880	Continued From page 80 twenty (20) seconds using antimicrobial soap and water under the following conditions: Before and after entering isolation precaution settings..." "Contact Precautions-Intended to prevent transmission of infectious agents, including epidemiologically important microorganisms, which are spread by direct or indirect contact with the resident or resident's environment." "Healthcare personnel caring for residents on Contact Precautions wear a gown and gloves for all interactions that may involve contact with the resident or the resident's environment." "Donning personal protective equipment (PPE) upon room entry and discarding before exiting the room is done to contain pathogens..." "Droplet Precautions-Intended to prevent transmission of pathogens spread through close respiratory or mucous membrane contact with respiratory secretions (i.e. respiratory droplets that are generated by a resident who is coughing, sneezing, or talking)." "...Healthcare personnel wear a mask for close contact with infectious agent." "Residents on Droplet Precautions who must be transported outside the room should wear a mask if tolerated and follow respiratory hygiene/cough etiquette." 3. On 03/18/2022 at 12:21 PM, the surveyor observed Resident [redacted] awake and alert sitting in	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	315263		03/31/2022

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 880	Continued From page 81 his/her wheelchair in the resident's room. The surveyor observed Resident [redacted] with a [redacted] and the resident stated that the nurses performed dressing changes to his/her [redacted]. The surveyor further observed Resident [redacted] sitting in his/her wheelchair with a [redacted] on the [redacted] on 03/21/22 at 10:20 AM, 03/21/22 at 1:03 PM, and 03/22/22 10:45 AM. According to the Resident Face Sheet, Resident #116 was admitted to the facility with diagnoses which included, but not not limited to, [redacted] A review of the Quarterly Minimum Data Set (MDS), an assessment tool dated [redacted], revealed that Resident [redacted] had a Brief Interview for Mental Status score of [redacted] indicating the resident was [redacted]. In addition, Resident [redacted] had a current diagnosis of [redacted] The MDS further revealed that Resident [redacted] needed limited assistance of one person for transfers, does not ambulate and the resident had a [redacted]. On 03/23/22 at 10:29 AM, the surveyor observed the Licensed Practical Nurse #3 (LPN) perform a [redacted] treatment for Resident [redacted]. Upon arrival into Resident [redacted]'s room, the surveyor observed Resident [redacted] lying directly on an uncovered mattress, with his/her [redacted] dressing removed and the resident's [redacted] was lying directly on the uncovered mattress. The	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	315263		03/31/2022

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 880	Continued From page 82 surveyor observed the treatment supplies lying directly on the overbed table without a clean field or barrier. The overbed table had visible circle marks on the table and the treatment supplies were placed directly next to used white Styrofoam cups. Upon entering the resident's room, the surveyor observed LPN #3 wearing gloves and then, with the assistance of the Certified Nursing Assistant (CNA), repositioned the resident on his/her left side and repositioned the right foot on the uncovered mattress. LPN #3 then proceeded to perform the [redacted] care without changing her gloves or performing hand hygiene. The LPN then performed the [redacted] care to the right foot lying directly on the uncovered mattress. When the wound care was completed and the dressing applied, LPN #3 then removed both gloves and applied a new pair of gloves, without performing hand hygiene, and then applied tape to the white [redacted] dressing on the right foot. At that time the surveyor interviewed LPN #3 who stated that prior to performing resident's wound care, she would set up the clean field stating, "I would clean the area as much as I possibly can." LPN #3 further stated that prior to the wound treatment, she opened all supplies, washed her hands, donned gloves, and placed a sheet or a chux (disposable underpad) under the right foot when doing resident's wound care. LPN #3 stated that she should have sanitized her hands when she changed her gloves, and the reason the wound treatment should be done on a clean area was to stop the spread of infection. During an interview with the surveyor on 03/23/22 at 12:44 PM, the Licensed Practical Nurse/Infection Preventionist (LPN/IP) stated the process for [redacted] treatment included creating a	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	315263		03/31/2022

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 880	Continued From page 83 clean field, such as putting down a paper towel or a sheet or something on the table prior to putting the supplies on the table, and further creating a clean field for the area of the body for the [redacted] treatment. The LPN/IP further stated that she expected the nurse to perform hand hygiene when changing gloves or from going from a dirty area to a clean area. The [redacted] care supplies should not be placed directly on the table without a barrier or next to old water cups or food because it could cause cross contamination. The LPN/IP expected the area of the body that required the [redacted] treatment should not be positioned directly on an uncovered mattress but should be on a clean field such as a chux or pad under the area. During an interview with the surveyor on 03/24/22 at 10:55 AM, the Director of Nursing (DON) stated the wound care process included to review the treatment order, take the treatment cart to the residents room, gather the treatment supplies, and knock on the resident's door prior to entering the room. The nurse should then set up the treatment supplies on a clean area such as on the bedside table and lay something on the bedside table as protection to put the supplies on. The nurse would then sanitize their hands, apply gloves and explain the procedure to the resident, provide privacy, take off the bandage, change gloves, wash hands, put on clean gloves, then do the treatment, remove gloves, sanitize hands, put on new gloves and then reposition resident and sign the treatment medication record. The DON further stated that the supplies should be placed on a clean area such as a sheet or towel and not directly next to empty cups. The DON stated that the nurse should have discarded the gloves and sanitized the hands, putting on clean gloves prior	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	315263		03/31/2022

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 880	Continued From page 84 to performing the [redacted] treatment. Review of the facility's policy titled "[redacted] Treatment Protocol and Procedure," dated 11/2021, revealed the procedure for wound treatment include but not limited to: wash hands before treatment, apply gloves, remove soiled dressing, remove gloves, wash hands, apply gloves, apply dressing treatment as ordered by physician, remove and discard gloves and wash and dry hands thoroughly. Equipment and supplies necessary included disposable cloths. Review of the facility's policy titled "Handwashing/Hand Hygiene," revised 08/15/21, reflected that hand washing/hand hygiene can be either handwashing for at least 20 seconds using antimicrobial soap and water or alcohol based handrub. Hand Hygiene is to be performed for the following conditions, which included but not limited to: before and after direct contact with residents, before and after changing a dressing, and after removing gloves. NJAC 8:39 19.4 (a)(c)	F 880		
F 886 SS=E	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including	F 886		5/5/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	315263		03/31/2022

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 886	Continued From page 85 but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19.	F 886		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	315263		03/31/2022

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 886	Continued From page 86 §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of other facility documentation, it was determined that the facility failed to administer routine testing, based on the COVID-19 county level of community transmission, for staff members not up-to-date (means a person has received all recommended COVID-19 vaccines, including any booster dose(s) when eligible) with all recommended COVID-19 vaccine doses. This deficient practice was identified for 25 of 113 facility staff including any individual who provides care, treatment, or other services for the facility and/or its residents and was evidenced by the following: During the Entrance Conference with the Administrator, the Vice President of Clinical Service (VPCS) and the Director of Nursing (DON) on 03/17/22 at 09:18 AM, the DON stated that the facility was "Green" which means that everyone is well and the facility is not in a COVID-19 outbreak. The Administrator confirmed that the facility was not in an outbreak and there were no positive staff or residents in the facility. The DON further stated that the	F 886	Element #1 The following staff members are now Up-To-Date in their vaccination series. -LPN received [redacted] vaccinations on [redacted], Boosted [redacted] -LPN received [redacted] vaccinations [redacted], Boosted 1[redacted] -CNA received [redacted] vaccinations [redacted], Boosted [redacted] -Physical Therapist received vaccinations [redacted], Boosted [redacted] -Registered Nurse received vaccinations [redacted] Boosted [redacted] -Housekeeper received vaccinations [redacted] Boosted [redacted] -Registered Nurse received vaccinations [redacted] Boosted [redacted]	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	315263		03/31/2022

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 886	Continued From page 87 facility is not testing staff at this time and was only testing new residents admitted to the facility. Review of the facility's Resident & Staff Outbreak Line List (a report documenting the positive staff and resident cases in the facility) reflected the first positive case of COVID-19 on 12/30/21 and the last positive case of COVID-19 on 01/28/22. Review of an e-mail dated 03/21/22 from the county Health Department, provided by the Administrator, reflected that the facility's COVID-19 outbreak concluded on 03/02/22. In preparation for the survey, the surveyor reviewed the COVID-19 county level of community transmission. On 03/16/22, the COVID-19 county level of community transmission was "Substantial (orange)," which reflected the minimum testing frequency of staff who are not up-to-date with all recommended COVID-19 vaccine doses was "Twice a week." Review of the facility's staff vaccination status, provided by the facility on 03/24/22, reflected the following staff were not "up-to-date" with all recommended COVID-19 doses: -Certified Nursing Assistant (CNA) received the [redacted]) vaccine on [redacted] with the recommended booster dose due [redacted] -Licensed Practical Nurse (LPN) received the [redacted] Vaccines on [redacted] and [redacted] with the recommended booster dose due [redacted] -LPN received the [redacted] Vaccines on 01/13/21 and [redacted] with the recommended booster dose due [redacted]. -LPN received the [redacted] Vaccines on [redacted] and [redacted] with the recommended booster	F 886	-Translator received vaccinations [redacted], [redacted], Boosted [redacted] -All other employees are being tested according to the county transmission rate including those listed below: -CNA received [redacted] vaccines on [redacted] No longer employed -CNA received [redacted] vaccines on [redacted] 9[redacted] -LPN received [redacted] vaccines [redacted] -CNA received [redacted] vaccines [redacted] -Cook received [redacted] vaccines [redacted] -Cook received [redacted] -TNA received [redacted] -Dietary aide received [redacted] -Cook received [redacted] vaccine [redacted] -Translator received [redacted] vaccines [redacted] -Staffing Coordinator received [redacted] vaccines [redacted] -Director of Housekeeping received [redacted]	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	315263		03/31/2022

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 886	Continued From page 88 dose due [redacted]. -CNA received the [redacted] Vaccines on [redacted] with the recommended booster dose due [redacted] -LPN received the [redacted] Vaccines on [redacted] and [redacted] with the recommended booster dose due [redacted]. -CNA received the [redacted] Vaccines on [redacted] and 0[redacted] with the recommended booster dose due [redacted] -CNA received the [redacted] Vaccines on [redacted] and [redacted] with the recommended booster dose due [redacted] -CNA received the [redacted] Vaccine on [redacted] with the recommended booster dose due [redacted] -Dietary Aide received the [redacted] Vaccines [redacted] and [redacted] with the recommended booster dose due [redacted]. -Physical Therapist received the [redacted] Vaccines on [redacted] and [redacted] with the recommended booster dose due [redacted] -Cook received the [redacted] Vaccines on [redacted] and [redacted] with the recommended booster dose due [redacted]. -Cook received the [redacted] Vaccine on [redacted] with the recommended booster dose due [redacted]. -Temporary Nurse Assistant received the [redacted] Vaccine on [redacted] with the recommended booster dose due [redacted] -Dietary Aide received the [redacted] Vaccine on [redacted] with the recommended booster dose due [redacted] -Registered Nurse (RN) received the [redacted] Vaccines on [redacted] with the recommended booster dose due [redacted] -Housekeeper received the [redacted] Vaccines on [redacted] with the recommended booster dose due [redacted] -RN received the [redacted] Vaccines on [redacted] and	F 886	vaccine [redacted] -CNA received [redacted] vaccine [redacted] -Staff will be notified by IP of eligibility of booster according to CMS guidelines. Element #2 All residents and staff have the potential to be affected by this deficient practice. Element #3 DON in-serviced IP on tracking the county positivity rate on the CDC.gov website to see what the county level is and how frequently we should test the staff. IP was in-serviced to ensure that staff received the booster 5 months after receiving Pfizer and Moderna and 2months after receiving the Johnson & Johnson vaccine and any staff not up-to-date would receive routine testing based on the extent of the virus in the community. Element #4 IP will review the county transmission rate weekly on the CDC.gov website to see what the recommendations are for routine testing of staff who are not up-to-date with all boosters. IP will report findings reported quarterly to the Quality Assurance performance Improvement committee for review and action as appropriate.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	315263		03/31/2022

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 886	Continued From page 89 [redacted] with the recommended booster dose due [redacted]. -Cook received the [redacted] Vaccines on [redacted] and [redacted] with the recommended booster dose due [redacted] -Translator received the [redacted] Vaccines on [redacted] with the recommended booster dose due [redacted] -Translator received the [redacted] Vaccines on [redacted] with the recommended booster dose due [redacted] -Staffing/Business staff member received the [redacted] Vaccines on [redacted] with the recommended booster dose due [redacted]. -LPN received the [redacted] vaccines on [redacted] and [redacted] with the recommended booster dose due [redacted] -Director of Housekeeping received the [redacted] Vaccines on [redacted] and 09[redacted] with the recommended booster dose due [redacted] -CNA received the [redacted] Vaccine on [redacted] with the recommended booster dose due [redacted] During an interview with the surveyor on 03/21/22 at 9:45, the Assistant Director of Nursing (ADON) stated that a few of the staff members needed to be boosted based on their up-to-date vaccine status. The ADON further stated that the Infection Preventionist (IP) handles testing. During an interview with the surveyor on 03/21/22 at 10:00 AM, the IP stated that she tests staff and residents weekly when the facility is in an outbreak, and currently the facility is not testing because the outbreak ended on 03/02/22. The IP further stated that she followed the county level of community transmission, and further stated that the Regional Nurse will send the county level of community transmission to the Director of	F 886		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	315263		03/31/2022

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 886	Continued From page 90 Nursing (DON) and the DON disbursed the information in an email. The IP stated that the county level of community transmission was "Low" and that testing of staff was not recommended. During an interview with the surveyor on 03/22/22 at 2:15 PM, the Vice President of Clinical Services (VPCS), in the presence of the DON, stated that she just received the Centers for Medicare & Medicaid Services (CMS) Memorandum QSO-20-38-NH Memorandum revised 03/10/22 from corporate on 03/18/22. The VPCS further stated that she counts on a representative from the New Jersey Hospital Association to update her on CMS Memorandums during the monthly call. During a follow up interview with the surveyor on 03/23/22 at 2:35 PM, the IP confirmed the facility was not currently testing staff for COVID-19, as the outbreak concluded on 03/02/22. The IP further stated that the facility was currently not testing staff who were not up-to-date with their vaccines because "We were not aware of the mandate." Review of the CMS QSO-20-38-NH Memorandum, revised 03/10/22, with an Effective Date of "Immediately," reflected "Routine testing of staff, who are not up-to-date, should be based on the extent of the virus in the community" and that "Facilities should use their community transmission level as the trigger for staff testing frequency." The Memorandum reflected the following routine testing intervals by County COVID-19 Level of Community Transmission: "Low (blue) Not recommended; Moderate (yellow) Once a week; Substantial (orange) Twice a week;	F 886		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	315263		03/31/2022

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 886	Continued From page 91 and High (red) Twice a week." The Memorandum further reflects "If the level of community transmission decreases to a lower level of activity, the facility should continue testing staff at the higher frequency level until the level of community transmission has remained at the lower activity level for at least two weeks before reducing testing frequency." NJAC 8:39-5.1(a)	F 886		