STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315263	A. BUILDING _____ B. WING _____	C 01/31/2022

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**

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F 000	INITIAL COMMENTS Complaint #: NJ151090, NJ150740, NJ149627, NJ149574 Census: 151 Sample Size: 13 The facility is not in compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities based on this Complaint Survey. A COVID-19 Focused Infection Control Survey was conducted by the New Jersey Department of Health. The facility was found to be in compliance with 42 CFR §483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Survey date: 01/31/2022 Sample size: 5	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);	F 580		2/1/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 02/24/2022

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F 580	Continued From page 1 (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Complaint Intake #NJ151090 Based on observations, interviews, record	F 580	F580 Element 1: Corrective Actions Nursing, therapy, dietician, and social	

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F 580	Continued From page 2 reviews, and facility policy reviews, it was determined that the facility failed to notify a resident representative (RR) of changes in the resident's [redacted] treatment orders, changes in medication, appointments, and presence of a [redacted] for [redacted] (Resident [redacted]) of [redacted] residents reviewed for the development of [redacted] or [redacted]. Findings included: 1. The facility admitted Resident [redacted] on [redacted] with diagnoses that included [redacted]. A review of the quarterly Minimum Data Set (MDS), dated [redacted] indicated the resident had a Brief Interview for Mental Status (BIMS) [redacted] indicating the resident had severe [redacted]. The MDS also indicated the resident was dependent on staff for activities of daily living (ADLs) except for supervision with eating. The MDS also indicated Resident [redacted] had [redacted] that was [redacted]. The care plan for Resident [redacted] with a review date of [redacted] indicated the resident had a stage [redacted] and was at risk for skin breakdown. The goal of [redacted] improvement was to be attained using an anti-pressure mattress, encouraging, and assisting the resident to reposition, laboratory work, [redacted] consultations, pressure reducing devices on the bed and chair, diet and supplements per orders, preventative skin care, pillows and positioning devices as needed, medications as ordered, dietary	F 580	services were re-educated about the facility procedure for notifying residents responsible party/resident representative (RR), of any significant change in condition including worsening cognition, decline in ADL□s, new or changed wounds, new orders, physician appointments, and any incident/accidents. The in- servicing included documenting said notification in resident□s medical record. Resident [redacted] The interdisciplinary team member and nursing staff that provided care to Resident [redacted] were counseled and re-educated about notifying the responsible party whenever a change in condition or medication/treatment change occurs. Element 2: Identification of at Risk Residents All residents have the potential to be affected by this deficient practice. Element 3: Systemic Change UM/charge nurse reviews the 24-hour report daily to ensure all potential resident changes in condition/declines in ADL□s, new or changed wounds, new orders and physician visits are addressed and reported appropriately. In addition, DON/UM/designee will bring information received from 24hour report to morning meeting for team discussion and delegation of duties to alert RR to changes in condition.	

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F 580	Continued From page 3 evaluation, incontinent care and repositioning on rounds. A review of the physician's orders for Resident and/or nurse's notes from admission until the resident's discharge indicated the following changes for the resident. There was no evidence that the resident's RR had been notified of any of the changes. - On Executive Order 26, 4.b., the nurse documented in nurse's note that the Executive Order 26, 4.b. on Resident had opened. A Executive Order care treatment was started that included cleansing the with) and applying Executive Order 26, 4.b.) and cover with a dressing daily. - On a nurse's note indicated Resident to the was . The treatment to the included cleaning with and applying . - On , the treatment to the was changed from). - On Resident treatment to the was . - On , the physician discontinued the to Resident and started a new treatment that included applying skin prep daily. - On the physician discontinued the and . - On 03/31/2021, Resident physician discontinued the to the and started a treatment that consisted of cleansing the with	F 580	Element 4: Quality Assurance The DON/Designee will review the charts of 10 residents to assure the RR is notified about any changes in condition, new orders, new wounds, and physician appointments weekly for one month then monthly times three months. Findings will be reported by the DON at the QA/QAPI monthly meeting for review and action as appropriate.	

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F 580	Continued From page 4 [redacted] and packing the [redacted] with [redacted]. - On [redacted], a review of the treatment administration record (TAR) indicated Resident [redacted], and treatments were discontinued. - On [redacted] the [redacted] was discontinued to the [redacted] and the physician ordered [redacted]. - On [redacted], the nurse indicated in the nurses' notes that Resident [redacted] was [redacted]" with [redacted] - On [redacted], the nurse indicated an [redacted] was inserted for [redacted]. - On [redacted], nurse's notes indicated a new [redacted] started for Resident [redacted] The [redacted] was [redacted] and the physician started the [redacted] to be completed [redacted]. - On 0[redacted], nurse's notes indicated Resident [redacted] was [redacted]. An [redacted] was observed on the resident's [redacted]. The note indicated the physician was notified, but there was no indication the RR had been notified. - On [redacted], nurse's notes indicated Resident [redacted] had been seen by the physician and [redacted] was ordered for a [redacted] - On [redacted], nurse's notes indicated Resident [redacted] was scheduled for a [redacted] to rule out [redacted]). - On [redacted], the physician discontinued the	F 580		

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F 580	Continued From page 5 [redacted] to Resident [redacted] and ordered the [redacted] with [redacted]. - On [redacted], a nurse indicated in the nurse's notes that Resident [redacted] had been scheduled for [redacted] to see if the resident had [redacted] in the [redacted] but transportation had not shown up. There was no indication when the appointment was made and no indication that the RR was made aware of the appointment or the appointment cancellation. - On [redacted], the [redacted] was rescheduled. The nurse indicated in notes that she had made the transportation company aware, but there was no indication that the RR was made aware. - On [redacted], the nurse documented Resident [redacted] was scheduled for a [redacted]). There was no indication the RR was made aware. - On [redacted] nurses' notes indicated Resident [redacted] received [redacted] for [redacted]. There was no indication the [redacted] was made aware. - On [redacted], the physician discontinued the [redacted] and ordered after cleansing Resident [redacted] with [redacted] to pack the [redacted] - On [redacted], nurses' notes indicated [redacted] and on [redacted]) was ordered to treat Resident [redacted]. - On [redacted], the physician was notified of the [redacted] and in addition to the [redacted], Resident [redacted] was started on [redacted] (an [redacted] There was no indication the RR was notified of the change in the resident's condition or the addition	F 580		

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F 580	Continued From page 6 of the new medications. Licensed Practical Nurse (LPN) #3 was interviewed on 01/25/2022 at 2:00 PM. The LPN stated nurses assigned to residents were responsible for calling RR for falls, changes in condition, medication changes if the medication change involves a psychoactive medication, changes in mental condition, and injuries of unknown origin. The nurse stated if a resident received intravenous medications such as antibiotics there was no need to call the RR since that was a standard order. The LPN stated she was unsure if the RR should be notified of a new diagnosis such as [redacted] LPN #2 was interviewed on 01/25/2022 at 2:59 PM. LPN #2 stated she had called the RR in [redacted] when she had transferred Resident [redacted] to the hospital for a [redacted]. The nurse stated when she called the RR in June 2021, the RR stated they were unaware of Resident [redacted]. LPN #2 stated the nurse assigned to the resident or the unit manager was responsible for RR notification. The notification included changes in condition, new [redacted], new medications to include [redacted]. She added either the nurse on the hall or the unit manager were responsible for notifying the RR about the improvement or decline in any [redacted] The Director of Nursing (DON) and the Administrator were interviewed on 01/26/2022 at 1:05 PM. The DON stated a resident's RR should be notified about any change in condition, [redacted], emergent needs, pressure ulcers, changes in medication, constant refusal of care, inserting or discontinuing a [redacted] She added	F 580		

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F 580	Continued From page 7 when an RR was notified about a resident's condition, the nurse was expected to document the conversation in the resident's medical record. The DON stated staff were expected to notify the RR about a resident's [Executive Order] status including improvement or decline of a [Executive Order], [Executive Order 26] of unknown origin or new [Executive Order 26]. The DON reviewed the nurse's notes for Resident [redacted] and stated based on the notes, it appeared the RR had not been notified of the [Executive Order 2], changes in treatment and changes in Resident [redacted]s condition. The Administrator stated she agreed with what the DON had stated. The facility's undated policy titled, "Notification of Changes" indicated under Overview of Components, "Requirements for notification of resident, the resident representative, and their physician: 1) An accident involving the resident, which results in injury and has the potential for requiring physician intervention. 2) A significant change in the resident's physical, mental, or psychosocial status. (i) A significant change includes deterioration in health, mental, psychosocial status in either life-threatening conditions or clinical complications. (3) A need to alter treatment significantly. (i) A significant treatment alteration includes the need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment."	F 580		
F 584 SS=E	New Jersey Administrative Code § 8:39-5.1(a) Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean,	F 584		2/1/22

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F 584	Continued From page 8 comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by:	F 584		

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F 584	Continued From page 9 Complaint Intakes #NJ149627, #NJ149574, and #NJ150740 Based on observations, interviews, and record reviews, it was determined the facility failed to keep the building's walls, floors, furniture and equipment (such as heating and air conditioning units) clean and well maintained, and plumbing functioning without leaks. This practice had the potential to affect all residents. Findings included: 1. During an initial tour of the facility on 01/24/2022 from 9:30 AM to 11:00 AM, the following were observed: - Room [redacted] Multiple towels and sheets were under the sink in the bathroom. The resident, who was identified by the facility as alert and oriented, stated both the toilet and the sink had been leaking. The resident added it was difficult to use the sink since running water made the sink overflow. - Room [redacted] The baseboard was loose and away from the wall by the air conditioning unit. The front of the heater was propped against the heater. Sheets and towels were on the floor under the sink. - Room [redacted] Brown stains, approximately two to three inches in diameter were on the bottom sheet and bedspread. - Room [redacted] Holes were in the wall in two separate areas approximately four to six inches in diameter. - Room [redacted] Two pillows without cases were under Bed [redacted] Wire was hanging from the ceiling. A dresser drawer for Bed [redacted] was open. Inside the drawer was observed to have dried brown stains.	F 584	F 584 Element One □ Corrective Actions The following corrective actions were completed immediately: Room [redacted] the towels and sheets under the sink were removed, the toilet and the sink were repaired. Room [redacted] The baseboard was fixed. The front of the heater was re attached to the heater, the sheets and the towels under the sink were removed. Room [redacted] The sheet and bedspread were immediately removed Room [redacted] The holes in the wall were repaired Room [redacted] The 2 pillows from under the bed were removed, the wire hanging from the ceiling was secured. The inside of the drawer was cleaned. Room [redacted] The floor and the wall on the outside of the door were cleaned Room [redacted] The floor was cleaned Room [redacted] The Floor was cleaned Room [redacted] The towels on the floor by the toilet were thrown out. All the issues regarding the toilet have been rectified. All the walls were wipe down. The loose screws and the L bracket were removed from the window sill. The bottom of the closet bed b drawers was repaired. Room [redacted]. The hole near the air conditioner was repaired Room [redacted] The closet door for bed [redacted] was replaced. The floor was cleaned. The tile in the shower room near room [redacted] was repaired. A shower curtain was hung. The area behind the toilet was cleaned.	

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F 584	Continued From page 10 - Room [redacted]: The floor was dirty and sticky. The wall on the outside of the door had dried brown stains. - Room [redacted]: The floor was dirty and sticky. - Room [redacted]: The floor was dirty and sticky. - Room [redacted] Multiple towels were on the floor by the toilet with black stains on the towels. The resident stated the toilet overflowed almost daily. A dried brown substance was on the side of the toilet. Walls by the closet had dried dark stains. Random loose screws and a random L-bracket were in the windowsill. The bottom of the closet for Bed [redacted] was missing drawer fronts. - Room [redacted]: A hole was in the wall near the air conditioning unit approximately four inches in diameter. - Room [redacted]: The closet door was missing for Bed [redacted] The floor by Bed [redacted] had dark stains and was sticky. - The shower room near Room [redacted]: Tile was broken with no shower curtains present. The area behind the toilet had a black substance on the floor. The blinds from the window were lying on the shower gurney. The baseboard heater was rusting and bent outward with sharp edges. - The day room: Tables were upside down with dirty gloves on the tables. Trash was on the floor beneath the baseboard heater. - Room [redacted]: Brown smears were on the floor. The trash bin in the room had no liner and had brown stains inside and out. The baseboard heater was falling off the wall. Trash was under the bed. - There was an ice chest in a small cubby near the nurses' station. The lid was broken and lying across the ice chest. The cart where the ice chest was sitting had dried red and brown areas on the shelves. - Room [redacted]: The baseboard heater was falling off the wall. Trash was in the windowsill. Quarter	F 584	Issues with blinds were rectified. The base Board heater was Painted and repaired. The day room was cleaned and the tables were appropriately placed. Room [redacted] was cleaned. The trash cans were replaced. The Baseboard heater was fixed. The Ice chest was replaced. The cart was cleaned. Room [redacted] The Baseboard heater was fixed. The trash was removed from the window sill, the bedspread on bed was changed. The beds were replaced, Trash under Bed was removed. The night stand was cleaned. New covers for all clean linen carts have been ordered. Room [redacted] ceiling tiles were replaced Residents [redacted] and [redacted] room [redacted] toilet was fixed. The towels were removed from the floor. The toilet was properly cleaned inside and out. The floor in the room was cleaned. The wall by the closet was cleaned. The loose screws and hardware were removed. The drawers at the bottom of the closet for bed [redacted] were replaced Resident [redacted] the Bedspread and the sheets were removed, trash was removed and floor cleaned Resident [redacted] resident [redacted] room [redacted] The hole near the air conditioner was repaired, the baseboard was fixed. The front of the heater was re attached to the heater, the sheets and the towels under the sink and toilet were removed. Sink and toilet fixed Resident [redacted] Room [redacted] ceiling tiles were replaced, privacy curtain replaced, floors cleaned	

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F 584	Continued From page 11 sized brown stains were on the bedspread of Bed [redacted]. Bed frames were rusty with built-up dirt. Trash under the bed included a clear plastic medication cup. The nightstand was covered with a dried brown substance. - Covers for the clean linen carts on all halls had cracked vinyl. - Room [redacted]: Ceiling tiles had brown stains that covered the entire 12-inch by 12-inch tile. During the initial tour on 01/24/2022 between 9:30 AM and 11:00 AM, Resident [redacted] and Resident [redacted] were interviewed; the residents shared a room. Both residents stated the toilet overflowed daily. On observation, there were multiple wet towels on the floor and at least one of the towels was almost black in color. Brown dried substances were observed on the side of the toilet. The residents complained of their floor staying dirty. Single gloves, paper trash and medication cups were seen on the resident's floor. The side of the wall by the closet had a dried brown substance that extended approximately two inches wide and four inches long. There were loose screws and a piece of hardware lying on the windowsill. The fronts of the drawers at the bottom of the closet for Bed [redacted] were missing, exposing rough edges. Resident [redacted] was interviewed on 01/24/2022 between 9:30 AM and 11:00 AM during the initial tour. The resident stated they had a bowel movement that morning, soiling the sheets, bedspread, and the cushion for the wheelchair. Resident [redacted] stated staff took the cushion away but left the sheets and bedspread. On observation, dried brown stains were seen on the bedspread and the bottom sheet. Trash, including a clear medication cup, was observed under the	F 584	Resident [redacted] room [redacted] floor was cleaned Toilets and sinks were checked to ensure they are properly working Resident rooms on all units were checked for holes in the walls, repairs were done as needed The baseboards and heaters were checked throughout the facility and repairs were done as needed Ceiling tiles were checked through the facility including resident rooms and were changed as needed All shower rooms were checked for broken tiles and were repaired as needed All rooms were checked for broken furniture and were repaired or replaced The floors and walls in all resident rooms were cleaned Element Two □ Identification of Residents Affected All residents have the potential to be affected by these practices. Element Three Systemic Changes Facility staff were reeducated on the importance of utilizing the maintenance log book to inform the maintenance department of needed repairs. Housekeeping staff was reeducated on policies and procedures for proper housekeeping and cleaning by the housekeeping supervisor. The assistant maintenance director will conduct rounds throughout the facility two times weekly and visually inspect the facility for needed maintenance and act upon findings. The assistant housekeeping supervisor	

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F 584	Continued From page 12 resident's bed. On 01/24/2022 during the initial tour between 9:30 AM and 11:00 AM, Resident [redacted] and Resident [redacted] were interviewed; the residents were roommates. Resident [redacted] pointed at a hole approximately two inches by two inches next to the floor by the air conditioning unit where the baseboard was loose and away from the wall. Resident [redacted] stated bugs came in through the hole. The residents also indicated the sink and toilet overflowed daily. Towels and sheets were observed on the floor by the toilet and sink to absorb the water. The front of the heating unit in the room was off and propped against the front of the heater. Resident [redacted] was interviewed during the initial tour between 9:30 AM and 11:00 AM. The resident identified several housekeeping and maintenance issues such as brown ceiling tiles, dirty privacy curtains, and sticky, dirty floors. The resident stated the housekeeping was "not so good" and described the facility as "shabby." Licensed Practical Nurse (LPN) #3 was interviewed on 01/25/2022 at 11:30 AM. The nurse was observed completing a treatment. The nurse acknowledged the floor in Resident [redacted]s room was dirty and sticky. LPN #1 was interviewed on 01/25/2022 at 2:18 PM. The nurse stated the cleanliness of the building had improved, but there was still room for improvement. She stated there were holes in the wall that needed to be repaired and baseboard heaters were falling off the wall. The Maintenance Director (MD) was interviewed	F 584	will conduct rounds throughout the facility two times weekly to visually inspect the facility and ensure that housekeeping needs are met. The administrator shall review the maintenance logs on a weekly basis to ensure that maintenance problems identified by the staff are corrected. Element Four - Quality Assurance Weekly, on an ongoing basis, the assistant maintenance director shall report results of his inspections to the maintenance director for scheduling of needed repairs. Repairs made on a weekly basis shall be reported to the administrator for review and follow-up as necessary. Quarterly the Maintenance Director will report inspection findings and actions taken at he QA committee for review and action as appropriate. On an ongoing basis, the assistant housekeeping supervisor shall report results of her rounds to the housekeeping director for correction as necessary. Housekeeping issues will be discussed at weekly management meetings and the Administrator will review and act upon issues reported. Quarterly the Housekeeping Director will report housekeeping inspection findings and actions taken to the QA committee for review and action as appropriate.	

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F 584	Continued From page 13 on 01/26/2022 at 8:10 AM. He stated that there was nothing approved by the corporation, and he had no written plan. He had started on [redacted] and was trying to go room to room with renovation of lights, painting, and anything else that needed to be done. The MD stated if anything required repairing, staff had a book at the nurse's station to log those issues. He added that either he or his assistant checked the book daily and made daily rounds throughout the facility. The MD stated he felt the facility was being maintained as it should be, adding that some of the residents were destructive. The MD stated he was also responsible for replacing tile on the floor or the wall, replacing closet doors, fixing baseboard heaters, and was responsible for clogged toilets and drains. The MD stated if the baseboard heaters had sharp corners, they presented a trip hazard and could increase pest entry into the building. Sinks and toilets that leaked presented both an infection control issue and a fall risk to the residents. The MD stated he should be notified about any hardware left in a resident's room. The MD stated the nursing department was responsible for the clutter in each resident's room. A review of the maintenance book at the nurse's stations revealed there had been nothing written in the book related to what was observed during the initial tour on 01/24/2022. The Housekeeping Supervisor (HS) was interviewed on 01/26/2022 at 8:30 AM. He stated housekeeping staff had a list that should be followed for cleaning rooms. The HS stated one housekeeper was assigned to each wing of the facility, with a total of twenty-five to twenty-seven rooms to clean. The HS stated the housekeepers	F 584		

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F 584	Continued From page 14	F 584		

arrived at work at 7:00 AM but did not bring the housekeeping carts to the floor until after breakfast. During the time breakfast was served, housekeepers were to clean the dining rooms (no communal dining at the facility at this time), nurses' stations, make rounds on all assigned rooms, and sweep those rooms that were excessively messy. The housekeepers should have all trash bins emptied by 7:30 AM. Before leaving for the day, at 3:00 PM, the housekeepers went through to make sure there were no rooms left dirty. The HS stated while housekeepers were responsible for cleaning the legs of the over-bed tables, bed frames, and other items in the residents' rooms, nursing was responsible for cleaning the tops, inside dresser drawers, and closets. The HS stated daily duties of the housekeepers included cleaning the trashcans, changing dirty privacy curtains, washing down bed frames and windows, and cleaning out windowsills.

After the completion of the HS interview at approximately 9:00 AM, the HS, MD, and the Administrator made rounds in the building along with the surveyor. The HS agreed the cleanliness of the building did not meet his expectations. He expressed concern at the overflowing trashcans, those that had no liner, the condition of the sticky floors, trash on the floor, and the condition of bed frames and privacy curtains. The MD stated he was not aware of all the issues shown to him. He stated he had not been notified of the maintenance issues. The MD stated the rounds were embarrassing. After rounds, he stated he no longer felt the building was clean. He added it was apparent liquids had been splashed on the walls and doors. He added he found the floors dirty and sticky during the rounds. The

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F 584	Continued From page 15 Administrator stated the cleanliness of the building was disappointing. Resident [redacted] was interviewed on [redacted] at 11:45 AM. Resident [redacted] was identified as the Resident Council President. Resident [redacted] stated the building was not as clean as it should be, but the resident thought housekeeping tried to keep the building clean. Resident [redacted] added there were some residents that had no respect for the building and would throw food and fluid around. A policy related to maintenance, housekeeping, and the environment was requested from the facility. The facility did not provide a policy. New Jersey Administrative Code: §8:39-31.4(a)	F 584		
F 684 SS=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: Complaint intake #NJ149574 and #NJ150740 Based on observations, interviews, record reviews, and review of facility policies, it was determined that the facility failed to provide pain medication as prescribed by the resident's physician for one (Resident [redacted]) of three residents	F 684	F684 Element 1: Corrective Actions Resident [redacted] no longer resides at the facility. Nursing staff that provided care to Resident [redacted] were counseled and re-educated about the provision of pain management medications including	2/1/22

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F 684	Continued From page 16 reviewed for the administration of pain medications. Findings included: 1. The facility admitted Resident [redacted] with diagnoses that included chronic obstructive pulmonary disease, major depression, bipolar disease, chronic pain, and post laminectomy. The 09/14/2021 Nursing Admission Evaluation indicated the resident rated their pain as a [redacted] on Executive Order 26, 4.b.. The location of the pain was identified as the back. The only thing listed as working was a "narcotic." A review of a physician's admission note dated Executive Order 26, 4.b., indicated Resident [redacted] had an active diagnosis of chronic pain. A review of the initial orders for Resident [redacted] dated [redacted] indicated the physician had approved orders for Resident [redacted] to receive [redacted] and [redacted] Additionally, the resident received [redacted] for [redacted], [redacted] mg every eight hours as needed for moderate pain, and [redacted] mg every six hours as needed for [redacted] A review of Resident [redacted] admission Minimum Data Set (MDS), dated [redacted], revealed a Brief Interview for Mental Status (BIMS) score of [redacted], indicating a Executive Order 26, 4.b. Executive Order 26, 4.b.. The MDS also indicated the resident received both scheduled and as-needed (PRN) pain medication for pain described as occasional	F 684	administration by the physician as ordered and effectiveness and follow up with the physician for accuracy and effectiveness. RN #2 was immediately re-educated regarding MD orders, documenting administration or refusals, and communicating with the physician and other shifts. Element 2: Identification of Extent of Problem All residents have the potential to be affected by this practice. Element 3: Systemic Change Nursing staff were re-educated regarding pain management protocols including dosing, timing, effectiveness, and following MD orders. Element 4: Quality Assurance UM/ADON/Designee will initially conduct a facility wide review of residents on pain management for effectiveness, communication with resident regarding pain management and completion of the medical record and MAR. Thereafter UM/ADON/Designee will monitor 5 of the identified residents for pain management effectiveness, communication with resident, completion of MARS and MD orders weekly x 4, then monthly x4 with findings reported monthly to the QAPI committee for review and action as appropriate.	

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and was not affecting the resident's ability to sleep or limiting daily activities. The intensity of the pain was rated as four on a zero through 10 scale.

A review of a physician's progress note, dated [redacted], indicated the [redacted] was discontinued, and the resident continued [redacted]

A review of the nursing progress notes indicated that on [redacted] Resident [redacted] was discontinued, and [redacted] was ordered scheduled [redacted] The times were entered on the medication administration record (MAR) as [redacted] Executive Order 26, 4.b. .

Resident [redacted] care plan, initiated [redacted], indicated the resident had a potential for pain related to Executive Order 26, 4.b. process. A goal of having the resident's pain controlled was to be achieved in part by administering any scheduled pain medications and to facilitate changes in pain management as needed.

A review of physician's orders indicated Resident [redacted] s primary care physician wrote a prescription on [redacted].

A review of a nursing progress note, dated Executive Order 26, 4.b. , indicated Registered Nurse (RN) #2 indicated an order was obtained for a one-time dose of the [redacted] to be given at [redacted] RN #2 indicated the nurse on the 7:00 AM to 3:00 PM shift would be made aware of the [redacted]. RN #2 wrote a telephone order on [redacted] indicating she received a

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F 684	Continued From page 18 telephone order from Resident [redacted] primary care physician to give Resident [redacted] now due to the resident's scheduled midnight [redacted]. A review of Resident [redacted] MAR indicated the resident's entry for the scheduled [redacted] had no initials, indicating the resident had not received the [redacted] - On Executive Order 26, 4.b., - On Executive Order 26, 4.b., - On Executive Order 26, 4.b., - On Executive Order 26, 4.b., - On Executive Order 26, 4.b. - On Executive Order 26, 4.b., - On Executive Order 26, 4.b., and on Executive Order 26, 4.b. initials were present with Executive Order 26, written below. [The space for Executive Order 26, 4.b. at midnight had been signed as received.] - On Executive Order 26, 4.b. The Executive Order 26, 4.b. MAR also had an entry for pain assessment each shift on a scale of 0 - 10 with 0 meaning no pain at all. The MAR revealed the following: - The pain level revealed for Resident [redacted] on [redacted] - The pain level revealed for Resident [redacted] on [redacted] - The pain level revealed for Resident [redacted] on [redacted] - The pain level revealed for Resident [redacted] on [redacted] - The pain level revealed for Resident [redacted] on [redacted] - The pain level revealed for Resident [redacted] on [redacted]. A review of Resident [redacted] individual controlled	F 684		

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drug record for Executive Order 26, 4.b. revealed the resident received the [redacted] outside of the time specified by the physician by more than one hour on seven different days. The time frames when Resident [redacted] received the [redacted] outside of the one-hour parameter included Executive Order 26, 4.b. Executive Order 26, 4.b. . The controlled drug record also revealed no [redacted] was signed out of the [redacted] box for Resident [redacted] on Executive Order 26, 4.b. at midnight, Executive Order 26, 4.b. at [redacted] at [redacted] and [redacted] at [redacted]. There was no explanation as to why three of the four doses were not given to the resident.

A review of a nurse's note identified as a monthly nurse's note, dated [redacted] indicated Resident [redacted] complained about other nurses not giving medication as ordered. The nurse indicated the resident had a history of [redacted] Executive Order 26, 4.b. . The nurse indicated the resident continued the scheduled [redacted] for pain.

A review of Resident [redacted] Executive Order 26, 4.b. MAR indicated the [redacted] was not initialed as given on Executive Order 26, 4.b. at 6:00 AM and midnight, Executive Order 26, 4.b. , and Executive Order 26, 4.b. PM.

A review of Resident [redacted] s Executive Order 26, 4.b. individual controlled drug record indicated on [redacted] the resident had [redacted] signed out as given at [redacted] .

Licensed Practical Nurse (LPN) #2 was interviewed on 01/25/2022 at 2:59 PM. LPN #2 stated she usually worked the 11:00 PM to 7:00

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F 684	Continued From page 20 AM shift and added she remembered Resident [redacted] LPN #2 stated Resident [redacted] focused on pain medication and would tell staff pain medication was not given on time. LPN #2 stated initially Resident [redacted] received [redacted] as needed, but the physician changed the medication to a scheduled dose. The nurse added Resident [redacted] complained about Registered Nurse (RN) #2 who primarily worked with the resident on the night shift. The Director of Nursing (DON) and the Administrator were interviewed on 01/26/2022 at 1:05 PM. The DON stated scheduled medications could be given one hour before and one hour after the scheduled time. The DON added if a scheduled medication was not given within that parameter, the physician should be called to see if the time could be changed. If a resident refused medications, the staff were expected to initial the square designated and enter the refusal on the back of the MAR. The nurse would also be expected to include this in the nurses' progress notes that the resident refused a medication or a treatment. The DON stated blanks on the medication administration record (MAR), or the treatment administration record (TAR), meant the medication was not given or the treatment was not completed. The DON reviewed the MAR for Resident [redacted] and stated the holes on the MAR were unacceptable. The DON added [redacted] should be given as close to the scheduled time as possible and should not include the one-hour parameter given for other medications. She added that while the nurses probably gave the medication, they probably forgot to sign. The Administrator, who was present at the time of the interview, stated she agreed with what the DON said on each subject and had nothing more to	F 684		

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F 684	Continued From page 21 add. On 01/27/2022 at 8:00 AM, RN #2 was interviewed. RN #2 stated she worked the 11:00 PM to 7:00 AM shift and remembered Resident [redacted]. RN #2 stated the time frame for giving medications was one hour before and one hour after the scheduled time. The nurse stated that if a resident refused medication she educated the resident, and if three days passed and the resident continued to refuse, she notified the physician. RN #2 added that with narcotics there was no one-hour time frame, and medications should be given as close to the scheduled time as possible. She added that if a hole was found on the MAR, that meant the medication was not given or the nurse forgot to sign it as given. RN #2 confirmed she had taken care of Resident [redacted] on [redacted] and confirmed she had written the telephone order dated [redacted] to give the resident [redacted]. She stated she arrived at work late that night and added it was 2:30 AM when she arrived. The nurse stated that when she arrived, Resident [redacted] informed her no one had given the scheduled midnight dose of [redacted]. RN #2 stated she had known Resident [redacted] primary care physician a long time and knew the physician would be mad if she awakened him for a medication that had been missed, so she just wrote the order to give the medication. The RN added she knew if she had not given Resident [redacted] the requested medication, she would have heard about it all shift. The nurse stated she had made an agreement with the resident that if the [redacted] was given at 3:00 AM then the resident would not receive the 6:00 AM dose. She added she had passed the information on to the next shift, and it was up to the day shift to figure out what to do about the	F 684		

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F 684	Continued From page 22 missed 6:00 AM dose. She added if the day shift wanted the resident to have the scheduled dose, the day shift could call the physician and gotten a clarifying order. On review of the controlled drug count sheet, it was pointed out the resident had gone nine hours without the scheduled [redacted] prior to the 3:00 AM dose and went another nine hours before getting the [redacted] The nurse had no comment. The DON came in to hear the nurse's interview and stated RN #2's actions were unacceptable. The DON stated writing the order for the [redacted] without the physician's consent exceeded the nurse's scope of practice. She confirmed Resident [redacted] had not received the [redacted] as ordered by the resident's physician. An undated facility policy titled, "Medication and Treatment Administration Time," indicated it was the policy of the facility to ensure the residents were free of significant medication errors. Under Procedure, the policy indicated, "When an order for medication is made by the attending physician it shall be administered in accordance with the medication and treatment administration time standard to the facility. UNLESS other specified by the MD [physician]." An undated facility policy titled, "Medication Administration," indicated the purpose of the policy was in part to administer medications at the right time.	F 684		
F 686 SS=G	New Jersey Administrative Code: § 8:39-29.2 (d) Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity	F 686		2/1/22

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	315263	A. BUILDING _____ B. WING _____	C 01/31/2022

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PALACE REHABILITATION AND CARE CENTER, THE	**315 WEST MILL ROAD MAPLE SHADE, NJ 08052**

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F 686	Continued From page 23 §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Complaint Intake # NJ151090 Based on observations, interviews, and record reviews, it was determined that the facility failed to provide Executive Order 26, 4.b. treatment for 1 (Resident [redacted] of [redacted] residents reviewed with Executive Order 26, 4.b. rs. This deficient practice resulted in Resident [redacted] developing a Executive Order 26, 4.b. which then got infected and resulted in the resident getting Executive Order 26, 4.b. Findings included: 1. The facility admitted Resident [redacted] on Executive Order 26, 4.b. with diagnoses that included Executive Order 26, 4 [redacted]. The resident was sent to the hospital for a Executive Order 26, 4.b. on Executive Order 26, 4.b. and returned to the facility on Executive Order 26, 4.b. . The Executive Order 26, 4.b. . A review of a 01/29/2021 Nursing Admission Evaluation indicated Resident [redacted] had a Executive Order 26 Executive Order 26, 4.b. and a Executive Order 26, 4.b. .	F 686	F686 Element 1: Resident [redacted] Executive Order 26, 4.b. [redacted] Review of clinical record for Resident [redacted] was conducted and RCA (root cause analysis) performed based on the findings in the alleged deficiency. Staff that provided care to Resident [redacted] during their residency received re-education regarding completing skin assessments, providing treatments as ordered timely and reporting changes is wounds to the physician and responsible party as required per facility policy and regulations. A skin assessment was completed for all residents with pressure ulcers to identify any unknown wounds or skin conditions to ensure proper follow up and treatments of any identified. No other unknown wounds were found. Element 2: Identification of Extent of	

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F 686	Continued From page 24 There were no measurements for the DTI or the Executive Order 26, 4.b.. A review of a history and physical, completed on Executive Order 26, 4.b. by the nurse practitioner (NP), indicated Resident Executive had a Executive Order 26 DTI with Executive Order 26, 4.b. surrounding the area. The NP also indicated the DTI had Executive Order 26, 4.b.). The NP ordered a Executive Order culture and sensitivity and Executive Order care for the Executive Order 26. The redness that had been previously noted on the Executive Order 26, 4.b. nursing admission assessment was not addressed by the NP. A review of the treatment administration record (TAR) revealed no treatment was started for Resident Executive C Executive Order 26, 4.b. when identified on admission. No interventions were noted on the TAR to help decrease the risk of the Executive Order Executive Order 26, 4.b.. The 02/04/2021 admission Minimum Data Set (MDS) revealed the resident had a Brief Interview for Mental Status (BIMS) Executive Order 26, 4.b. indicating the resident was Executive Order 26, 4.b.. The resident's hearing was adequate, the resident had clear speech, was understood and was able to understand, and vision was adequate. The resident had no behaviors identified including rejection of care. The resident had a diagnosis of Executive Order 26, 4.b. The MDS indicated the resident had the Executive Order 26, 4.b. on the Executive Order 26. A review of the nurses' notes dated Executive Order 26, 4.b. indicated the previously Executive Order 26, 4.b. Executive Order 26, 4 opened. The nurse described the Executive Order 26, 4.b. Executive Order 26, 4.b. sized with Executive Order 26, 4.b. and Executive Order 26, 4.b.. The nurse's note revealed	F 686	Problem All residents have the potential to be affected by this practice. Element 3: Systemic Change Licensed nursing staff were reeducated about completing the proper skin assessments as ordered per facility policy and physician orders and properly documenting characteristics of skin abnormalities with appropriate interventions. Licensed nurses received reeducation about reporting new Executive Order 26, change sin Executive Order size and treatment changes to the Responsible Party and the physician as appropriate. Element 4: Quality Assurance The UM/ADON will conduct 10 random audits on residents at risk for skin breakdown as determined by their Executive Order 2 score to ensure proper treatments, consultations and interventions are in place. Audits will be conducted weekly x 4, then monthly x4 with findings reported by the ADON monthly to the QAPI committee for review and to ensure ongoing compliance.	

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a new order had been received to cleanse the Executive Order 26, 4.b. with Executive Order 26, 4.b., apply Executive Order 26, 4.b. and cover with a dressing daily. The nurse added Resident [redacted] was non-compliant with off-loading their [redacted] despite encouragement. A review of the Executive Order 26, 4.b. TAR for Resident [redacted] revealed no treatment was started for the Executive Order 26, 4.b. until the area opened on Executive Order 26, 4.b. at which time a treatment to cleanse the [redacted] with Executive Order 26, 4.b. and apply [redacted] daily was added to the TAR. There was no indication the Executive Order 26, 4.b. had been assessed or treated prior to Executive Order 26, 4.b.. No interventions were added to the TAR to help the Executive Order 26, 4.b..

A review of weekly cumulative measurements provided by the Director of Nursing (DON) indicated the first weekly [redacted] measurement for the Executive Order 26, 4.b. occurred on Executive Order 26, 4.b., with the Executive Order 26, 4.b. This was 10 days after the Executive Order 26, 4.b. was identified as open. There was no indication of what stage the [redacted]r was.

A review of the physician's progress notes revealed the first mention of a Executive Order 26, 4.b. [redacted] for Resident [redacted] occurred on [redacted]. The physician listed the Executive Order 26, 4.b. as Problem #6, with no other information given about the Executive Order 26, 4.b..

A review of the Executive Order 26, 4.b. TAR indicated on Executive Order 26, 4.b. the previous treatment was discontinued. A new treatment was started on Resident Executive Order 26, 4.b. that consisted of cleansing with Executive Order 26, 4.b. and applying Executive Order 26, 4.b. ointment Executive Order 26, 4.b..

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The physician's progress note, dated Executive Order 26, 4.b. indicated the facility should continue in-house treatment of the Executive Order 26, 4.b. The physician indicated Executive Order 26, (Executive Order 26, 4.b. Executive Order 26, 4.b.) would be added to the resident's medication.

A review of physician's orders for Executive Order 26, 4.b. indicated the physician ordered a new treatment for the Executive Order 26, 4.b.. The treatment consisted of cleaning the Executive Order 26, 4.b. with Executive Order 26, 4.b. Executive Order 26, 4.b. used to clean infected Executive Order 26, Executive Order 26, 4.b.) and Executive Order 26, 4.b. with Executive Order 2 moistened gauze daily and as needed. The gauze packing would be covered with border gauze and changed daily.

A review of the Executive Order 26, 4.b. TAR for Resident Execu indicated treatments were ordered twice daily. All treatments were completed except for Executive Order 26, 4.b. There was no indication the resident had refused the two treatments on that day.

On Executive Order 26, 4.b., the measurements listed for the Executive Order 26, 4.b. and was described as a Executive Order 26, 4.b..

A review of physician's progress notes dated Executive Order 26, 4.b. indicated the physician ordered a low Executive Order 26, 4.b. for Resident Execu

A review of the physician's orders revealed on Executive Order 26, 4.b. the treatment to Resident Execu 's Execu Executive O was discontinued due to the DTI to the being healed.

A review of the Executive Order 26, 4.b. TAR for Resident Execu

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indicated weekly skin assessments had been added for the nurse to complete on the 7:00 AM to 3:00 PM shift. All entries for skin assessments were initialed to indicate the assessment had been completed. Weekly skin assessments had not been completed from admission on Executive Order 26, 4.b..

On Executive Order 26, 4.b. a review of orders revealed the Executive Order 26, 4.b. order for a Executive Order 26, 4.b. had been transcribed and added to the TAR, indicating the resident had just received the air mattress on Executive Order 26, 4.b.. This was Execu days after the air mattress was ordered. The TAR also revealed weekly skin assessments had been signed as completed by the nurses.

A review of physician's orders indicated on Executive Order 26, 4.b. the previous Executive Order 26, 4.b. was discontinued. The physician ordered the Executive Order Executive Order 26, 4.b. to be cleansed with Executive Order 26 Executive Order 26, and then packed with a Executive Order 26, 4.b. Executive Order 26, 4.b. nd covered. The treatment was ordered to be completed daily.

A review of the physician's progress note, dated Executive Order 26, 4.b. indicated Resident Execu had a Executive Order 2 Executive Order 26, 4.b.. On Executive Order 26, 4.b., the physician revealed the measurements for the Executive Order 26, 4.b.

A review of physician's orders for Executive Order 26, 4.b. indicated the Executive Order 26, 4.b. packing was discontinued, and the Executive Order 26, 4.b. Executive O would be packed with gauze moistened with Executive Order 26 Executive Order 26 daily

A review of nursing progress notes, dated

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F 686	Continued From page 28 Executive Order 26, 4.b., indicated Resident Executi was Executive Order 26, 4.b. an Executive Order 26, 4.b. of the Executive Order 26, 4.b.. The resident was Executive Order 26, 4.b. Executive Order 26, 4.b. The Nursing Admission Evaluation indicated on readmission the Executive Order 26, 4.b. Executive Order 26, 4.b. measured Executive Order 26, 4.b. with dark pink/red tissue and Executive Order 26, 4.b. A review of a nurse's note dated Executive Order 26, 4.b. indicated Executive Order 2 care had been provided secondary to bowel incontinence. The nurse documented, "To this nurse the area is markedly Executive Order 26, 4.b. & (and) Executive Order 26, 4.b. There was no indication the physician or the responsible party was notified of the change in Resident Executive Order 26, 4.b.. A review of physician's progress notes dated Executive Order 26, 4.b., indicated Resident Executive Order 26, 4.b. Executive Order 26, 4.b. considered a Executive Order 26 by the physician. A review of the Executive Order 26, 4.b. TAR for Resident Execu indicated missed treatments on Executive Order 26, 4.b. Executive Order 26, 4.b., and Executive Order 26, 4.b. through Executive Order 26, 4.b. These dates were not signed off as completed. There was no evidence the resident had refused treatments on these seven days. The TAR also indicated the Executive Order 26, 4.b. skin assessment had not been signed as completed. A review of the physician's progress notes dated Executive Order 26, 4.b., indicated Resident Executive physician ordered Executive Order 26, 4.b. (Executive Order 26, 4.b. Executive Order 2 and Executive Order 26, 4.b. twice daily to aid in Executive Order 26, 4.b..	F 686		

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A review of the physician's progress notes dated Executive Order 26, 4.b., indicated Resident Executive Order 26, 4.b. was considered a [redacted]. The physician documented the resident's current [redacted] care would continue.

On Executive Order 26, 4.b. a review of nurse's notes indicated Resident [redacted] was seen by the [redacted] nurse practitioner and a treatment change was ordered. The nurse documented the [redacted] Executive Order 26, 4.b. and a treatment using [redacted] would be used. [redacted] would be applied around the [redacted] and then covered with a bordered gauze.

A review of the cumulative measurements for Resident Executive Order 26, 4.b., provided by the DON, indicated on [redacted] the [redacted] measurements were Executive Order 26, 4.b..

A review of the [redacted] TAR for Resident [redacted] resident received treatments Executive Order 26, 4.b. consisting of applying [redacted] daily. The entry for [redacted] was marked as discontinued on [redacted] 1. On [redacted] an entry had been added that indicated the [redacted] for Resident [redacted] would be cleansed with [redacted] and [redacted] ned gauze packed into the [redacted] twice daily. The entry start date was listed as 07/05/2021. There was no indication Resident [redacted] had refused treatments between [redacted] and [redacted]. There was no evidence the resident refused treatment on these nine days.

A review of the [redacted] TAR indicated [redacted] Executive Order 26, 4.b. continued twice a day. There was no indication any skin assessments were

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completed in August. On Executive Order 26, 4.b. an entry was made on the TAR to reposition Resident Executive side to side every two hours while in bed and to document any refusals. There were also entries to use a wedge cushion for positioning and to use a cushion to the chair when the resident was out of bed with the instructions to limit Resident Executive time out of bed to two hours. The entries were identified as a FYI (for your information). There was no documentation that indicated Resident Execu had refused treatments or turning and positioning. Another entry on the TAR with a start date of Executive Order 26, 4.b. indicated the resident was on an every two hours turn schedule. The entry was divided between the three shifts. Ten shifts had been omitted.

A review of the physician's orders, dated Executive Order 26, 4.b. indicated a change in treatment. The Executive Order 26, 4.b. would be cleansed with Executive Order 2 Executive Order 26 and Executive Order 26, 4.b. would be applied around the Executive Order 2 . The Executive Order would be covered with Executive Order 26, 4.b. (Abdominal Dressing - a highly absorbent dressing) and secured with paper tape daily.

A review of the Executive Order 26, 4.b. TAR indicated the entry for every two hours turn schedule had been changed to a FYI entry. The Executive Order 26, 4.b. Executive Order 26, 4 t continued from Executive Order 26, 4.b. through Executive Order 26, 4.b. . On Executive Order 26, 4.b. the treatment was entered as cleanse Resident Executive Executive Order 26, 4.b. with Executive Order 26, 4.b. and pack the Executive Order with Executive Order 26, 4.b. .

On Executive Order 26, 4.b. an Executive Order 26, 4.b. Executive Order 26, 4 of Resident Executive Order 26, 4.b. was scheduled to rule out Executive Order 26, 4.b.

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F 686	Continued From page 31 Executive Order 26, 4.b. . Transportation did not show up, so the MRI was rescheduled for Executive Order 26, 4.b. . A review of nurse's notes indicated on Executive Order 26, 4.b. and Executive Order 26, 4.b. the nurse placed a call to the hospital's radiology department to get the results of the Executive O The nurse documented she was notified the Executive O results were not ready. The results of the Executive when received, identified Resident Execu with a Executive Order 26, 4.b. ." On Executive Order 26, 4.b. Resident Executi was scheduled to have a Executive Order 26, 4.b. r Executive Order 26, 4.b.) medication administration. On Executive Order 26, 4.b. Resident Execut was started on Executive Order 26, 4.b.) for six weeks to treat Executive Order 26, 4.b. in the Executive Order 26, 4.b. A review of the Executive Order 26, 4.b. TAR for Resident Execu indicated the resident had not received the ordered treatments of cleansing the Executive Order 26, 4.b. and packing with Executive Order 26, 4.b. on Executive Order 26, 4.b. and Executive Order 26, 4.b. . These dates were not signed off as completed. There was no evidence the resident had refused treatment on these two days. A review of the quarterly MDS, dated Executive Order 26, 4.b. , revealed the resident had no behavior or rejection of care during the assessment period. The MDS indicated the resident required extensive to total assistance for Executive Order 26, 4.b. Executive Order 26, 4.b. and bathing. The MDS indicated Resident Execu had one Executive Order 26, 4.b. that was not present on admission. The resident now had a BIMS score of Executive Order 26, 4.b. indicating	F 686		

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severe cognitive impairment.

A review of the Executive Order 26, 4.b. Resident Executive revealed missing documentation that confirmed treatment of cleansing the Executive Order with Executive Order 26, 4.b. and packing with Executive Order 26, 4.b. was done on Executive Order 26, 4.b., Executive Order 26, 4.b. Executive Order 26, 4.b., and 10/29/2021. There was no evidence the resident had refused treatments on these four days. The weekly skin assessment was not signed as completed on Executive Order 26, 4.b..

A review of Resident Executive C care plan, last reviewed on 1 Executive Order 26, 4.b., indicated the resident had a Executive Ord Executive Order 26, 4.b. and was at risk for skin breakdown. The goal of Executive Order improvement was to be attained using an anti-pressure mattress, encouraging, and assisting the resident to reposition, Executive Order consult, pressure-reducing devices on bed and chair, diet and supplements per orders, preventative skin care, pillows and positioning devices as needed, medications as ordered, dietary evaluation, incontinent care, and repositioning on rounds.

A review of physician's orders, dated Executive Order 26, 4.b. indicated the previous treatment of the Executive Orde Executive Order 26, 4.b. was discontinued and again the Executive Orde Executive Order 2 would be cleansed and packed with gauze moistened with Executive Order 26, 4.b.. The physician ordered the dressing to be changed daily.

A review of Resident Executive Order 26, 4.b. TAR indicated an order to clean the Executive Order 26, 4.b. Executive Ord with Executive Order 26, 4.b. and pack with Executive Order 26 Executive Order 26, 4.b. daily. The treatment was signed as completed from Executive Order 26, 4.b.

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Executive Order 26, 4.b. . On the treatment entry was handwritten, "D/C [discontinue] Executive Order 26, 4." There was no treatment signed as completed from Executive Order 26, 4.b. (seven days) when the new treatment started. The entry "turn and position" was written as a FYI (for your information) with no expectation staff would sign when completed.

A review of Resident Executive Order 26, 4.b. monthly orders indicated dietary interventions used to help Resident Executive Order 26, 4.b. included super cereal (a Executive Order 26, 4.b. al) at Executive Order 26, 4.b. Executive Ord a nutritional snack high in calories and vitamins) at dinner and, Executive Order 2 (Executive Order 26, 4.b. protein needed for Executive Order healing) Executi milliliters Executive Executive Order 26, 4.b. . Other interventions listed on the monthly orders included every-two-hour turning schedule, cushion for the Executive Order 26, 4 chair (Executive Order 26, 4.b.) when out of bed, limit being out of bed to two-hour intervals, reposition and turn every two hours and document resident refusal, and off Executive Order 26, 4.b. in bed as tolerated. Review of the TAR failed to reveal Resident Executi had refused any pressure ulcer reducing interventions or refusal of pressure ulcer care.

A review of the Executive Order 26, 4.b. TAR for Resident Executi revealed an entry for treatments to be completed daily on the Executive Order 26, 4.b. . The TAR had been signed designating completed treatments on Executive Order 26, 4.b. and on Executive Order 26, 4.b. . The rest of the dates for December were blank. There was no evidence the resident refused treatment to the Executive Order 26, 4.b. for 24 days in December.

A review of measurements, presented by the DON indicated on Executive Order 26, 4.b. Resident Executive

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Executive Order 26, 4.b.

A review of progress notes from admission on Executive Order 26, 4.b. through Executive Order 26, 4.b. revealed no evidence that Resident Executive had refused or was non-complaint with any pressure ulcer reducing interventions or refusal of Executive Order 26, 4.b..

LPN #2 was interviewed on 01/25/2022 at 2:59 PM. LPN #2 stated she remembered Resident Execut was admitted with a Executive Order 26, 4.b. and added Executive Order 26, 4.b. was applied after incontinence as a preventative measure. The LPN stated the protective cream should have been added to the TAR. LPN #2 stated the last time she cared for Resident Executive she sent the resident to the emergency department with a Executive Order 26, 4.b. Executive Order 26, 4.b.. She stated she had not liked the way the resident's Executive Order 26, 4.b. looked. She stated this was in Executive Or Executive Or. The LPN stated that without documentation there was no way to know for sure the cream had been applied to the resident's Executive Order 26, 4.b. LPN #2 added if blanks were found on the TAR that was indicative the treatment had not been completed.

Resident Executive primary care physician (PCP) was interviewed by phone on Executive Order 26, 4.b. at 11:44 AM. The PCP stated she remembered Resident Execut and added the resident had Executive Order 26, 4.b. of the Executive Order 26, 4.b. for which Resident Execut had received Executive Order 26, 4.b. The PCP stated she felt Resident Executive Order 26, 4.b. was unavoidable due to the resident's overall medical condition was "just not that good." The PCP stated if a treatment was not signed as done, it was concluded the treatment was not done as she

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PALACE REHABILITATION AND CARE CENTER, THE	**315 WEST MILL ROAD MAPLE SHADE, NJ 08052**

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F 686	Continued From page 35	F 686		

had ordered but added in this case, she thought the nurses probably just forgot to sign. She stated even missing a treatment or two would not affect the outcome for this resident.

The Director of Nursing (DON) and Administrator were interviewed on 01/26/2022 at 1:05 PM. The DON stated if a resident refused treatment, the nurse was expected to ask the resident more than once. If the resident continued to refuse, the nurse was expected to notify the PCP, initial the square and circle indicating a refusal, and then document on the back of the TAR that the resident had refused the treatment. The DON stated areas not signed for treatments meant the treatment was not completed as ordered and may result in a decline of the Executive Order 26, 4.b. The DON reviewed the TAR for Resident Executive Order 26, 4.b. and stated by the number of empty spaces and lack of signing that those treatments had been completed, there was a lot of education that needed to be done. She stated based on the TAR, Resident Executive Order 26, 4.b. had not received treatments to the Executive Order 26, 4.b. as ordered by the PCP. The DON stated she was unsure if the resident got Executive Order 26, 4.b. treatments since there was no entry for a treatment of any kind on Resident Executive Order 26, 4.b. TAR from Executive Order 26, 4.b. until Executive Order 26, 4.b. for a total of Executive Order 26, 4.b. days without documentation of a Executive Order 26, 4.b. Executive Order 26, 4.b.

A review of an undated facility policy titled, "Skin Alteration Reporting and Documentation", indicated under Procedure, Paragraph 2 that a "Licensed nurse/Nurse Supervisor will indicate location and description of the skin alteration on the" skin occurrence report. Paragraph 3 continues, "Licensed nurse/supervisor reports the occurrence to the Physician, Responsible

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F 686	Continued From page 36 Party/Family, and DON/Designee and indicate that on the skin incident report". Paragraph 6 of the policy indicated the licensed nurse/supervisor documents the occurrence in the progress notes to include, "date, time, location of skin alteration, measurements of skin alteration, treatment initiated, names of persons notified, response of the family/significant other at the time of notification and document that 2 licensed nurses did a full head to toe skin assessment." New Jersey Administrative Code § 8:39-27.1(e)	F 686		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder	F 690		2/1/22

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F 690	Continued From page 37 receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Complaint Intake #NJ151090 Based on observations, interviews, record reviews, and facility policy review, it was determined that the facility failed to provide appropriate [redacted] to 1 (Resident [redacted] of [redacted] resident observed for [redacted] and failed to follow the care plan to secure an [redacted] for [redacted] (Resident [redacted] and Resident [redacted]) of [redacted] residents observed with [redacted] Findings included: 1. The facility admitted Resident [redacted] with diagnoses that included [redacted]. A quarterly Minimum Data Set (MDS), dated [redacted], revealed the resident had a Brief Interview for Mental Status score of [redacted] indicating the resident was [redacted]. The resident was not identified with refusal of care or other behaviors. Resident [redacted] was identified as dependent on staff for personal hygiene and bathing.	F 690	F690 Element 1: Corrective Actions C.N.A. #1 was immediately re-in serviced on the proper procedure for the provision of am care/bed bath including peri care per the facility policy. Resident [redacted] is provided with incontinence care and staff who provide care to this resident have been re-educated to ensure proper incontinence care is provided. Resident [redacted] and Resident [redacted] had the [redacted] immediately secured and staff that provided care to these Residents were counseled and re-educated. LPN #3 was re-in serviced on facility procedure for [redacted]. The Unit Manager/Charge Nurse on each unit reviewed the care plans for residents dependent for incontinence care, and/or have an [redacted] with the nursing staff to assure proper incontinence care is provided. Element 2: Identification of at Risk Residents	

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F 690	Continued From page 38 A review of Resident [redacted]'s care plan, last reviewed on [redacted], indicated the resident was [redacted] and required assistance with daily care. An observation was made on [redacted] AM of Certified Nursing Assistant (CNA) #1 providing incontinent care to Resident [redacted]. Unit Manager (UM) #1 was also in the room. CNA #1 had completed the resident's upper body. Using the same cloth, CNA #1 made one swipe from top to bottom on Resident [redacted] area. The CNA did not open the resident's labia nor did the CNA wash either side of the resident's [redacted] area. The CNA used soap on the washcloth but did not rinse the soap before using a towel to dry Resident [redacted] area. A review of laboratory results for Resident [redacted] revealed the resident had no [redacted] infections during the year of [redacted]. CNA #1 was interviewed on 01/25/2022 at 1:35 PM. CNA #1 described the correct procedure for incontinent care as wiping the [redacted] from front to back making sure to use a different part of the cloth to clean [redacted]. The CNA acknowledged she had not parted the resident's [redacted], had only cleaned down the [redacted], and had not rinsed the soap from the resident's [redacted]. She stated she was nervous and forgot. She acknowledged she had been taught to clean not only the middle of the [redacted] but also to separate the [redacted] and clean each side as well. An observation of the product used to clean the resident by CNA #1 and the surveyor revealed the directions to include rinse well and dry after washing.	F 690	All residents have the potential to be affected by this practice. Element 3: Systemic Changes Nursing staff was re-in serviced on providing AM care, peri care and catheter care to residents including securing catheters. The facility policy for peri care and catheter care was reviewed and updated and nursing staff received re-education. The policy for suprapubic care was reviewed and updated to include the procedure for securing the tube to prevent dislodging. Nursing staff received re-education regarding the revised policy. Element 4: Quality Assurance Each Unit Manager/charge nurse will observe the care of 5 incontinent residents per week on each unit x 4 weeks, then 4 residents per month x 4 months to assure care is provided in accordance with facility procedures. The results of these audits will be submitted monthly to the DON for review, and monthly to the QAPI Committee for review and action, as appropriate. UM/charge nurse will observe Residents with suprapubic catheters on their units to assure they are properly secured to prevent dislodging daily x5, weekly x4 and monthly x4. The results of these audits will be submitted monthly to the DON for review, and monthly to the QAPI Committee for review and action, as	

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F 690	Continued From page 39 UM #1 was interviewed on 01/26/2022 at 10:00 AM. The UM stated she had noticed that CNA #1 had not separated Resident Executive Order 26, 4.b. and provided proper incontinent care. The UM stated she had already addressed the issue with CNA #1 along with using the same cloth to provide incontinent care as she had used for cleansing the resident's upper body. She stated not providing proper incontinent care, using the same cloth, and not rinsing the soap after cleansing could cause an increased risk of a Executive Order 26, 4.b. Executive Order 26, 4.b.). The UM added not rinsing the soap off could also cause irritation to the resident's skin and increased dryness of the resident's skin. The Director of Nursing (DON) and the Administrator were interviewed on 01/26/2022 at 1:38 PM. The DON stated when providing incontinent care, Executive Order 26, 4 should be separated and cleansed from top to bottom on both sides and the middle using clean sections of the cloth for each wipe. :The Administrator stated she expected staff to follow the policy for incontinent care. The facility policy titled, "Pericare and Catheter Care Standard of Care," with no revision date, indicated under Procedure, paragraph 6, "gently wash, rinse and dry perineal area, wiping from 'clean' urethral area toward 'dirty'" rectal area to avoid contaminating urethral area with germs from the rectal area." 2. The facility admitted Resident Execu with diagnoses that included Executive Order 26, 4.b. . A quarterly Minimum Data Set (MDS), dated Executive Order 26, 4.b. indicated the resident had a Brief Interview for Mental Status Executive Order 26, 4.b.	F 690	appropriate.	

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F 690	Continued From page 40 This indicated the resident had Executive Order 26, 4.b. impairment. The MDS indicated the resident required extensive to total assistance for all activities of daily living (ADLs) and indicated the resident required an Executive Order 26, 4.b. due to the diagnosis of Executive Order 26, 4.b. A review of the care plan for Resident [redacted], last reviewed on Executive Order 26, 4.b. indicated the resident had a Executive Order 26, 4.b. that included an intervention of securing the [redacted] to minimize infection or trauma. An observation was made on Executive Order 26, 4.b. Licensed Practical Nurse (LPN) #4 attempted to provide Executive Order 26, 4.b. care to Resident [redacted]. The resident refused to allow the nurse to perform care but did allow the nurse to visualize the [redacted] insertion site. The insertion site of the [redacted] was noted to be bleeding slightly. There was no [redacted] secure observed to hold the Executive Order 26, 4.b. in place. The LPN stated there should be a leg strap or some way to secure the [redacted], adding she was not sure what happened to the strap, but she would get another. LPN #3 was interviewed on 01/25/2022 on 2:00 PM. LPN #3 stated she was unsure if the facility had a policy to secure [redacted] but added if a [redacted] was not secured it could become accidently dislodged. The Director of Nursing (DON) and the Administrator were interviewed on 01/26/2022 at 1:40 PM. The DON stated [redacted] should be secured. She added if any resident preferred not to have the [redacted] secured, that preference should be care planned. The Administrator stated	F 690		

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F 690	Continued From page 41	F 690		

she expected staff to follow the facility policy.

A review of the undated facility policy titled, "Suprapubic: Care, Maintenance and Reinsertion of the Established Catheter," did not address securing the suprapubic catheter.

3. The facility admitted Resident [redacted] with diagnoses that included [redacted]. A review of a quarterly Minimum Data Set (MDS), dated 10/14/2021, revealed the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] indicating the resident had severe [redacted]. Resident [redacted] was identified on the MDS as requiring extensive to total assistance with most of the activities of daily living (ADLs). The MDS indicated Resident [redacted]

A review of Resident [redacted]s care plan, with a [redacted] review date, indicated Resident [redacted] required a [redacted]. Interventions were to keep the [redacted] patent including securing the [redacted].

Registered Nurse (RN) #1 was observed providing [redacted] for Resident [redacted] on [redacted]. Upon observation, Resident [redacted] site [redacted] RN #1 stated she had called the primary care provider that morning and received orders to clean the area with [redacted] and apply a [redacted]. The resident's [redacted] was not secured to the resident's [redacted]. When interviewed at that time, RN #1 stated the tubing should be secured to the resident's [redacted] to minimize pulling.

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F 690	Continued From page 42 The Director of Nursing (DON) and the Administrator were interviewed on [redacted] at [redacted]. The DON stated [redacted] should be secured. The DON stated Resident [redacted] preferred not to have the resident's [redacted] secured, and the DON added the care plan should reflect the resident's preference and not have an intervention to secure the [redacted]. The Administrator stated she expected staff to follow policy. A review of the undated facility policy titled, "Suprapubic: Care, Maintenance and Reinsertion of the Established Catheter," did not address securing the suprapubic catheter. New Jersey Administrative Code: §8:39-27.1(b)	F 690		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and	F 842		2/1/22

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F 842	Continued From page 43 (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided;	F 842		

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F 842	Continued From page 44 (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to maintain residents' medical records in an organized manner that enabled consistent treatment, medications, [redacted] care, and interventions for pressure ulcer prevention to be determined for two (Resident [redacted] and Resident [redacted] of [redacted] residents whose records were reviewed for [redacted], pain medications, and [redacted]. Findings included: 1. The facility admitted Resident [redacted] with diagnoses that included [redacted]. On [redacted] a [redacted]" area on the [redacted] opened. The resident was sent to the hospital for a [redacted] infection in the [redacted] on [redacted] and [redacted] on [redacted]. On [redacted] the nurse indicated in the progress notes that an [redacted] was inserted for [redacted] and due to the [redacted]. A review of the treatment administration records (TAR) for Resident [redacted] indicated the following were not signed off as administered or completed:	F 842	F842 Element 1: Corrective Actions Resident [redacted] and Resident [redacted]. Nursing staff that did not document properly were counseled and re-educated. Nursing staff were re-in serviced on signing MAR/TAR at the time of administration and double checking to be sure all medications and treatments have been provided as ordered throughout the shift. Element 2: Identification of at Risk Residents All residents have the potential to be affected by this deficient practice. Element 3: Systemic Change The facility is in the process of implementing an electronic medication administration record where the nurse will be alerted to a missing signature via a color-coded system. This information will also appear on the facility EMAR/TAR dashboard for facility administration view and monitoring of compliance with administration and signing for all medications and treatments.	

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F 842	Continued From page 45 - Executive Order 26, 4.b.: 1. Off load heels in bed as tolerated every shift. The TAR indicated this had not been signed off as completed 15 times over three shifts (three shifts per day times 31 days = 93 opportunities). 2. Executive Order 26, 4.b. output each shift. This was not signed off as completed 20 out of 93 opportunities. 3. Executive Order 26, 4.b. and Executive Order 26, 4.b.. This was not signed off as completed two out of three opportunities. - Executive Order 26, 4.b.: 1. Executive Order 26, 4.b. on in the morning and off in evening. The TAR indicated this had been not signed off as administered 12 out of 90 opportunities. 2. Executive Order 26, 4Executive Order 26, with Executive Ord Executive Order 26, 4.b. and cover with dry dressing. This was not signed off as completed three out of 20 opportunities. 3. Executivexecutive Order 26, 4.b. while in bed as tolerated. This was not signed off as completed 10 out of 90 opportunities involving all three shifts. - Executive Order 26, 4.b.: 1. Record output from Executive Order 26, 4.b.. This was omitted 12 out of 54 opportunities. 2. Treatment for Executive Order 26, 4.b.. This was omitted 10 out of 49 opportunities (07/13/2021 - 07/31/2021; dressing changes were twice a day). 3. Executive Order 26, 4.b. as tolerated every shift. This was omitted 13 out of 44 opportunities. - Executive Order 26, 4.b.: 1. Executive Order 26, 4.b. while in bed. This was omitted 12 out of 93 opportunities. 2. Turn every two hours. This was omitted eight out of 93 opportunities. 3. Record Executive Order 26, 4.b. output. This was omitted 13 out of 93 opportunities. - September 2021: 1. Executive Order 26, Order 26, 4.b. This was omitted 27 out of 90 opportunities. 2. Executive Order 26, 4.b. Executive Order 26, 4.b.. This was omitted four out of 24 opportunities. 3. Record Executive Order 26, 4.b.. This was omitted 31 out of 90 opportunities. 4. Executive Ord care every shift. This was omitted 28 out of 90 opportunities. 5. Executive Order 26, 4.b. This was omitted two out of 29 opportunities	F 842	Nursing staff received re-education about proper documentation of administration of medications and treatments. Element 4: Quality Assurance ADON/UM will monitor the MARS/TARS for signatures every shift daily (1 hour prior to end of shift) daily for 2 weeks, weekly x4 weeks and monthly x 4 with findings reported monthly in aggregate by the ADON to the QAPI committee for review and action as appropriate. After the implementation of the electronic EMAR system the UM will monitor the facility dashboard daily for compliance with signatures and report findings in aggregate monthly to the QAPI committee to assure sustained compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315263	A. BUILDING _____ B. WING _____	C 01/31/2022

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

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F 842	Continued From page 46 (09/01/2021 - 09/07/2021; the dressing changes were twice a day). - Executive Order 26, 4.b.: 1. Apply Executive Order 26, 4.b. to Executive Order 26, 4.b. . This was omitted four days out of 31 opportunities. 2. Off load heels while in bed. This was omitted 30 shifts out of 93 opportunities. 3. Executive Order 26, 4.b. Executive Order 26, 4.b. . This was omitted four out of 31 opportunities. 4. Executive Order 26, 4.b. to Executive Order 26, 4.b. daily. This was omitted two out of 31 opportunities. 5. Record Executive Order 26, output every shift. This was omitted 30 out of 93 opportunities. - Executive Order 26, 4.b.: 1) Executive Order 26, 4.b. for Executive Order 26, 4.b.. This was omitted 10 shifts out of 16 days. 2. Executive Order 26, 4.b. Executive Order 26, 4.b. . This was omitted five out of 15 opportunities. - Executive Order 26, 4.b.: 1. Executive Order 26, 4.b. every shift. This was omitted 13 out of 93 opportunities. 2. Executive Order 26, 4.b. . This was omitted on 22 out of 93 opportunities. 3. Record foley output every shift. This was omitted 26 out of 93 opportunities. - Executive Order 26, 4.b.: 1.Executive Order 26, 4.b.. This was omitted one out of two days with two days signed as completed after Resident Execu was Executive Order 26, 4.b. 2. Executive Order 26, 4.b. output every shift. Two shifts were omitted. Licensed Practical Nurse (LPN) #2 was interviewed on 01/25/2022 at 2:59 PM. LPN #2 stated the TAR was signed with the nurses' initials when the treatment ordered had been completed. She added without the nurses' initials by the treatment entry on the TAR there would be no way to know if a treatment had been completed. The Primary Care Provider (PCP) was	F 842		

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	315263	A. BUILDING _____ B. WING _____	C 01/31/2022

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**

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F 842	Continued From page 47	F 842		

interviewed by phone on 01/26/2022 at 11:44 AM. The PCP stated if a treatment was not signed off as completed, it was concluded the treatment was not done as ordered. The PCP added in this case, she thought the nurses probably just forgot to sign their initials designating completion of the treatments.

The Director of Nursing (DON) and Administrator were interviewed on 01/26/2022 at 1:05 PM. The DON stated her expectations were for treatments and medications to be given as ordered by the physician. She added if a resident refused a medication or a treatment, the expectation was for the nurse to sign the entry and circle the entry and then write on the back of the TAR or the medication administration record (MAR) why the order had not been completed. The DON stated complete blanks on the MAR or TAR indicated a medication was not offered or a treatment was not completed. She reviewed the TARs for Resident [redacted] and stated there was a lot of education to be given to the nurses. The DON stated based on the review of Resident [redacted]'s TAR she could not prove Resident [redacted] had received treatments as ordered by the physician. The Administrator reviewed the TAR for Resident [redacted] and stated she agreed with the DON.

2. The facility admitted Resident [redacted] with diagnoses that included Executive Order 26, 4.b. [redacted]

A review of the medication administration record (MAR) and the Controlled Drug Record for Resident [redacted] indicated the following were not

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	315263	A. BUILDING _____ B. WING _____	C 01/31/2022

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**

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F 842	Continued From page 48 signed off as being administered: - [redacted] MAR: 1. [redacted] This was omitted 12 out of 31 days (four times a day times 31 days = 124 opportunities). 2. Pain assessment every shift. This was omitted three out of 93 opportunities. - Executive Order 26, 4.b. MAR: 1. [redacted] daily. This was omitted on one of 30 opportunities. 2. [redacted]. This was omitted four out of 68 opportunities. - Executive Order 26, 4.b. from Executive Order 26, 4.b. Executive Order 26, 4.b.. There were multiple dates/times written over making the correct date/time hard to distinguish. Licensed Practical Nurse (LPN) #2 was interviewed on 01/25/2022 at 2:59 PM. LPN #2 stated the TAR and MAR were signed with the nurses' initials when the treatment ordered had been completed or the medication given. She added without the nurses' initials by the treatment entry on the TAR and MAR there would be no way to know if a treatment or medication had been given. Resident [redacted] physician was interviewed by phone on 01/26/2022 at 11:44 AM. The physician stated if a treatment was not signed as completed, it was concluded the treatment was not done as ordered. The physician stated she knew the staff well and added in this case she thought the nurses probably just forgot to sign their initials designating medications had been given. The Director of Nursing (DON) and Administrator were interviewed on 01/26/2022 at 1:05 PM. The DON stated her expectations were for treatments	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 842	Continued From page 49 and medications to be given as ordered by the physician. She added if a resident refused a medication or a treatment, the expectation was for the nurse to sign the entry and circle the entry and then write on the back of the TAR or the MAR why the order had not been completed. The DON stated complete blanks on the MAR or TAR indicated a medication was not offered or a treatment was not completed. She reviewed the MARs for Resident [redacted] and stated there was a lot of education to be given to the nurses. The DON stated based on the review of Resident [redacted] MAR she could not prove Resident [redacted] had received medications as ordered by the physician. The Administrator reviewed the MAR for Resident [redacted] and stated she agreed with the DON. New Jersey Administrative Code: § 8:39 - 35.2(d)(6)(9)	F 842		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315263 Y1	A. Building B. Wing Y2	3/8/2022 Y3

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

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0580	Correction	ID Prefix F0584	Correction	ID Prefix F0684	Correction
Reg. # 483.10(g)(14)(i)-(iv)(15)	Completed	Reg. # 483.10(i)(1)-(7)	Completed	Reg. # 483.25	Completed
LSC	02/01/2022	LSC	02/01/2022	LSC	02/01/2022
ID Prefix F0686	Correction	ID Prefix F0690	Correction	ID Prefix F0842	Correction
Reg. # 483.25(b)(1)(i)(ii)	Completed	Reg. # 483.25(e)(1)-(3)	Completed	Reg. # 483.20(f)(5), 483.70(i)(1)-(5)	Completed
LSC	02/01/2022	LSC	02/01/2022	LSC	02/01/2022
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
1/31/2022	☐ YES ☐ NO