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 02/04/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS COMPLAINT # NJ142500 CENSUS: 149 SAMPLE SIZE: 9 THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: C#: NJ142500 Based on interviews, record reviews and review of other pertinent facility documentation, it was determined that the facility failed to provide a safe environment for a [redacted] impaired resident (Resident #3) with a roommate (Resident #2), who had a diagnosis of [redacted] and a history of [redacted] and [redacted] towards others. On 1/17/2021 at 7:45 a.m., Resident #2 physically assaulted Resident #3, sending that resident to the hospital. Resident #2 ,was refusing [redacted] medications that controlled [redacted]	F 689	1)Resident #2 was sent to ER and was admitted to crisis Unit and has not returned and no longer resides at the facility. Resident #3 was discharged to the hospital on [redacted] and has not returned. 2) All Residents have the potential to be affected by this deficient practice. Residents charts were reviewed to identify any resident with [redacted] and other [redacted] diagnoses that predispose	2/25/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 03/04/2021

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 689	Continued From page 1 behaviors prior to this incident. The Pre-Admission Screening and Resident Review (PASRR) Level II was not followed, it indicated that Resident #2 needed to be seen for a [redacted] visit that was due upon re-admission on [redacted] at the facility, however this visit was done on [redacted], 15 days later. On this day, Resident #2 was seen by the Advanced Practice Nurse- Certified [redacted], who documented that the resident needed inpatient [redacted] treatment to stabilized [redacted] behaviors towards others and this was not possible due to refusal of medications. The facility also failed to follow its policy titled "Safety and Supervision of Residents." This deficient practice was evident for 1 of 9 sampled residents (Resident #2) for behaviors by the following: According to the facility Admission Record (AR), Resident #2 was admitted on [redacted] with diagnoses which included but were not limited to, [redacted]. According to the Minimum Data Set (MDS), an assessment tool dated [redacted], Resident #2 had a Brief Interview of Mental Status (BIMS) score of [redacted] which indicated the resident was [redacted]. 2. According to the facility AR, Resident #3 was admitted to the facility on [redacted] and readmitted on [redacted] with diagnoses which included but were not limited t [redacted]. According to the MDS, dated [redacted]	F 689	them to [redacted], or [redacted] behavior toward others in order to identify those who may require room changes. Two additional room changes were made to ensure the safety of other Residents, based on compatibility and cognitive impairment. 3)Facility contracted with a new [redacted] group that will assess residents on admission and be able to directly admit to a [redacted] facility as needed. Staff was educated 12/7/20, and re-education commence 1/27/21 and is ongoing ,regarding: *behavior monitoring including de-escalation of agitated resident *staff, resident and other resident safety *crisis intervention *refusing meds or care and notifying MD of such and timely compliance with MD recommendations/orders The facility has implemented and alert charting log to monitor residents with disruptive behaviors, increase agitation or change in mental condition, which will determine the level of monitoring such as q 15, q 30 and 1:1 as needed. The Admission Director and Social Service Director were educated on review of all the Pre-Admission PASSR documents and proper communication of pertinent information to the Administrator and Director of Nursing. Care plans of all residents were audited	

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Resident #3 had [redacted] and [redacted] problems and was [redacted] The MDS also indicated that Resident #3 needed extensive assistance with ADLs.

Review of the Facility Reportable Event (FRE), a New Jersey Department of Health (NJDOH) document used by healthcare facilities to report incidents dated [redacted] with an event date of [redacted] and a "time of event" of 7:45 a.m., revealed the following:

According to the FRE, Resident #2 had a physical altercation with Resident #3. The document revealed that on [redacted], at approximately 7:45 a.m., the call light was on in Resident #2's and Resident #3's room, and the Licensed Practical Nurse (LPN #1) asked the Certified Nurse's Assistant (CNA #1) to respond to the residents' room. The FRE indicated when CNA #1 entered the room; the CNA observed [redacted] on Resident #3's [redacted] and [redacted] The FRE revealed CNA #1 asked Resident #2 what happened, and Resident #2 stated, [redacted] CNA #1 called for LPN #1, who responded and observed Resident #3 lying on his/her side; the resident's [redacted] and [redacted] and there was [redacted] on Resident #3's [redacted] and [redacted] The LPN called for the Registered Nurse (RN #1), who saw [redacted] on Resident #3's [redacted] and [redacted] The FRE also indicated the [redacted] of Resident #3's [redacted] and [redacted], and the resident was unable to open his/her [redacted]

Further review of the FRE indicated RN #1 assessed Resident #3, the resident's SpO2 [redacted] ([redacted] The FRE indicated Resident #3 was administered [redacted] at [redacted] and the resident's [redacted] then

F 689

for and adjusted as needed for:
*behaviors
[redacted] eval and follow up
[redacted] medications

PASSR Level II documents are reviewed on admission for each new admission and readmission to ensure those with [redacted] dx and/or who exhibit [redacted] or [redacted] behaviors are seen by [redacted] within 72 hours.

PASSR Level II documents and care plans of Residents who display [redacted] [redacted], and/or [redacted] behaviors were reviewed to ensure these Residents are receiving [redacted] care as needed and care plan interventions address required supervision and to ensure proper room placement with residents who are alert and oriented.

4)DON/designee will continue to conduct random audits of all residents displaying [redacted] behaviors daily x 2 weeks, then weekly x 4 weeks, then bi-weekly x 1 month.

DON/designee will conduct audits of residents who have [redacted] dx. that predispose them to [redacted] and [redacted] [redacted] toward others daily x 2 weeks, then weekly x 4 weeks, then bi-weekly x 1 month.

The results of the audits with corrective actions will be reported by the DON in aggregate at the QAPI meeting monthly.

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F 689	Continued From page 3 increased to [redacted]). The FRE revealed 911 was immediately called, Resident #2 was placed on one-to-one observation until the police arrived, and both residents were sent to different hospitals to be evaluated. The FRE indicated the facility concluded that Resident to Resident Abuse was substantiated. A review of the "Individual Statement Form (ISF) dated [redacted], written by CNA #1, showed at "Approximately 7:45 a.m., (LPN #1) asked me to go into room (number) because the call light was on. When I went into the room, I pulled the curtain, and I noticed dark stuff on (Resident #3's) pillow. I turned the light on, and I saw [redacted] on (his/her) [redacted] and the [redacted] The ISF also indicated, CNA #1 asked Resident #2 what happened, and Resident #2 responded, [redacted] I immediately yelled for the nurse to come, and she came and asked me to get the nurse from [redacted] Wing." A review of the ISF dated [redacted], written by LPN #1, revealed that on [redacted] at 7:45 a.m., the nurse noticed the call light was on and asked CNA #1 to go to the room then the CNA yelled that (Resident #3) was hurt and to please come to the room to assess. LPN #1 explained, "Upon entering the room, I noticed (Resident #3) was lying on (his/her) side, (the resident's) [redacted] was [redacted], and there was [redacted] also on his/her [redacted] and [redacted] A review of the ISF dated [redacted], written by RN #1, revealed that on [redacted] at 7:45 a.m., the RN was called by LPN #1 to Resident #2's and Resident #3's room. When RN #1 arrived in the room, there was [redacted] on Resident #3's [redacted] and [redacted] coming out of the resident's [redacted]. The ISF also revealed Resident	F 689		

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F 689	Continued From page 4	F 689		

#3' s [redacted] was [redacted], and the resident could not open [redacted]. Further review of the ISF showed 911 was called, and [redacted] was noted to be on both of (Resident #2's) [redacted]. The RN also wrote she asked Resident #2 what happened, and the resident did not answer.

Review of Resident #2's Care Plan (CP) dated [redacted] showed the following:

Under: Focus: Resident #2 has episodes of [redacted] (as evidenced by) [redacted] R/T (related to) [redacted] impairment, [redacted].

Under: Goal showed "Will not harm self or others, Will not strike others ... through the target date."
Under: "Interventions" included: "Administer medication per physician orders...If behavioral intervention strategies are not working, leave (if safe to do so) and reapproach later..."

A review of the "Physician's Orders" revealed the following:

[redacted] mg (milligram) Tablet. Give 3 tablets [redacted] mg) orally at bedtime for [redacted].
[redacted] mg [redacted]. Give 2 tablets ([redacted] mg) orally daily for [redacted]
[redacted] Tab [redacted] mg [redacted] ([redacted]). Give 1 tablet orally daily for [redacted].

A review of the [redacted] "Medication Administration Record (MAR)" showed Resident #2 refused all of the above medication as follows:

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[REDACTED] mg on
12/31/2020.
[REDACTED] mg [REDACTED] on
12/24/2020, 12/30/2020 & 12/31/2020.
[REDACTED] Tab [REDACTED] mg on
12/24/2020, 12/25/2020, 12/26/2020, 12/28/2020, 12/30/2020 and 12/31/2020.

A review of the [REDACTED] MAR showed Resident #2 refused the following medications:

[REDACTED] mg on 1/1/2021, 1/2/2021, 1/3/2021, 1/4/2021, 1/5/2021.
[REDACTED] mg [REDACTED] on
1/1/2021, 1/2/2021, 1/3/2021, 1/4/2021, 1/5/2021, 1/6/2021, 1/12/2021, 1/13/2021, 1/14/2021.
[REDACTED] Tab [REDACTED] mg on
1/6/2021, 1/7/2021, 1/12/2021, 1/13/2021, 1/14/2021, 1/15/2021 and 1/16/2021.

During an interview on 1/27/2021 at 11:47 a.m., the Unit Manager (UM) stated if a resident refused medications for more than 3 consecutive days. The medical doctor (MD) is notified, and a nurse's note is completed. The UM explained she would encourage the resident to take the medications and explain why he/she needed to take the medications. The UM indicated when Resident #2 refused the medications, there was nothing else done or no extra supervision provided.

A review of the Interdisciplinary Progress Note (IPN) revealed on [REDACTED] at 1:30 p.m., Resident #2 became combative with staff, hitting the CNA multiple times by following the staff out of the room and had to be sent out to [REDACTED] for evaluation.

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F 689	Continued From page 6	F 689		

During an interview on [redacted] at 12:20 p.m., the Administrator stated Resident #2 was sent out to [redacted] on [redacted] (him/her.)" The Administrator explained Resident #2 was ".. [redacted] ..." The Administrator indicated that Resident #2 was admitted to the hospital and returned on [redacted] to the facility.

Review of the MR revealed Resident #2 was readmitted to the facility on [redacted] with the following recommendations:

According to the "Pre-Admission Screening and Resident Review (PASRR) Level II," dated [redacted], upon admission/readmission to the facility, Resident #2 was to have a [redacted] consultant immediately.

Further review of the MR showed no evidence that Resident #2 was seen by the [redacted] group immediately upon returning to the facility on [redacted] per the PASSR II recommendations. However, the MR revealed that Resident #2 was not seen by the [redacted] group for evaluation until [redacted], fifteen days after readmission to the facility despite displaying medication refusals upon return to the facility and [redacted] behaviors on [redacted] and [redacted].

During an interview on 1/27/2021 at 1:10 p.m., the Social Worker (SW) indicated, the PASRR was correct that a [redacted]) evaluation should have been completed immediately when Resident #2 was readmitted. The SW also stated, "I do not know why it was not done."

A review of IPN dated [redacted] at 9:30 a.m., written by LPN #1, showed nurse went into the

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F 689	Continued From page 7 room to assess Resident #3, noticed [redacted] on Resident #2 [redacted], and immediately ran to Resident #3 and noticed he/she was [redacted] and his/her [redacted] and [redacted] on his/her [redacted] The IPN also revealed that 911 and [redacted] were called, and both residents were sent out to the hospital for evaluation. During an interview on 1/27/2021 at 11:47 a.m., the Surveyor asked the UM how was Resident #2 being monitored; the UM stated Resident #2 had behavioral monitoring done every shift, every day noted on a "Target Behavioral Symptom Sheet." The UM explained Resident #2 had no additional supervision. A review of [redacted] [redacted] Medication Monthly Flow Records [redacted])," "Section I: Target Behavioral Symptoms, revealed monitoring of symptoms 3. [redacted], 4. [redacted], 5. [redacted], 12. [redacted] and 13. [redacted] for (Resident #2) every shift: Day, Evening, and Night every day. According to the [redacted], Resident #2 had no identified behaviors on [redacted] Day Shift, however, the IPN showed that the resident was [redacted] on [redacted] at 7:00 a.m., screaming and calling staff [redacted] [redacted]" According to the [redacted] Resident #2 had no identified behaviors on [redacted] Night Shift, however, the IPN showed that the resident was [redacted] on [redacted] at 2:30 a.m. yelling in the hallway. During an interview on 1/20/2021 at 2:00 p.m., the SW indicated she tries to protect and keep other residents safe by telling staff to avoid confrontation with Resident #2. The SW also stated, "I inform staff to keep a safe distance." A review of "Medication Management	F 689		

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F 689	Continued From page 8 Assessment, (MMA)" dated [redacted] completed by the APN-C (Advanced Practice Nurse-Certified) [redacted] revealed the following recommendation for (Resident #2) "... requires (inpt.) [redacted] treatment due to his/her [redacted] behavior as he/she is a harm to others. Also, stabilization at the facility is not possible due to refusal of medications". During a telephone interview on 1/20/2021 at 12:10 p.m., the APN-C stated Resident #2 was aggressive and unable to be treated at the facility since the resident refused his/her medications. The APN-C explained she met with Resident #2, and the Resident was difficult to have a conversation with and was [redacted] and [redacted]. The APN-C also stated, "I felt (Resident #2) was unsafe to be around others." The APN-C also said she spoke to the Administrator, Social Worker, and the UM about the recommendations for Resident #2. However, the MR showed no documentation that the APN-C concerns were addressed. During a second telephone interview on 1/20/2021 at 1:15 p.m., the APN-C stated that in the [redacted] monitoring would not be appropriate for Resident #2. She also stated the resident needed an [redacted] facility, and "the (facility) was not appropriate for this resident (Resident #2)." During an interview on 1/20/2021 at 1:40 p.m., the UM stated she was responsible for following up on the [redacted] recommendations. A review of the facility policy titled "Safety and Supervision of Residents" dated 2001, with a revised date of December 2007, revealed the	F 689		

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F 689	Continued From page 9 following: Under "Policy Statement" "Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities." Under "Policy Interpretation and Implementation" " ...2. Safety risks and environmental hazards are identified on an ongoing basis through a combination of employee training, employee monitoring, and reporting processes; ..." Under "Resident-Oriented Approach to Safety" " ...5. Monitoring the effectiveness of interventions shall include the following: a. ensuring that interventions are implemented correctly and consistently; b. evaluating the effectiveness of interventions; c. modifying or replacing interventions as needed; and d. evaluating the effectiveness of new or revised interventions." N.J.A.C.: 8.39-4.1 (a) (5) N.J.A.C.: 8.39-27.1 (a)	F 689		