

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315263	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/29/2024
NAME OF PROVIDER OR SUPPLIER Palace Rehabilitation and Care Center, The		STREET ADDRESS, CITY, STATE, ZIP CODE 315 West Mill Road Maple Shade, NJ 08052	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>48618</p> <p>COMPLAINT #: NJ172102</p> <p>Based on observations, interviews, record review, and review of other pertinent facility documentation, it was determined that the facility failed to report an alleged violation of misappropriation of resident property to the New Jersey Department of Health (NJDOH).</p> <p>This deficient practice was identified for 2 of 7 residents (Resident #58 and Resident #365) reviewed for unnecessary medications and was evidenced by the following:</p> <p>1.) On 10/22/24 at 12:14 PM, the surveyor interviewed Resident #58 who reported that pain medications were always available when requested. The resident further stated that there was never a time when he/she did not receive pain medication when the resident asked for it.</p> <p>A review of the Admission Record, an admission summary, revealed that the resident had diagnoses which included, but were not limited to: borderline personality disorder, dorsalgia (a sensation of unpleasant feeling indicating potential or actual damage to some body structure felt in the back), and osteoarthritis (a degenerative disease that worsens over time, often resulting in chronic pain).</p> <p>A review of the quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 7/19/24, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 12 out of 15, which indicated that the resident's cognition was moderately impaired.</p> <p>A review of the resident's electronic medical record (EMR) revealed the resident had the following physician's orders:</p> <p>-Percocet Oral Tablet 5-325 MG (Oxycodone w/ Acetaminophen) Give 1 tablet by mouth every 4 hours as needed for Pain (4-6) For moderate pain 4-6 on pain scale/ MD aware of drug side effects/ drug interactions. -Start Date: 12/12/23 -End Date: 6/16/24</p> <p>-Percocet Oral Tablet 5-325 MG (Oxycodone w/ Acetaminophen) Give 2 tablet by mouth every 4 hours as needed for Pain (7-10) For severe pain 7-10 on pain scale/ MD made aware of side effect and dosage -Start Date: 12/12/23 -End Date: 02/21/24</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of the resident's Individual Patient's Controlled Drug Record for February 2024 revealed the following:</p> <p>A sheet with the date range of 1/23/224 - 2/5/24:</p> <p>2/1/24: 2 Percocet tablets were signed out at 4 PM, 8 PM</p> <p>2/2/24: 2 Percocet tablets were signed out at 3 PM</p> <p>2/3/24: 2 Percocet tablets were signed out at 7 AM, 12 PM, 4 PM, 8 PM</p> <p>2/4/24: 2 Percocet tablets were signed out at 8 PM</p> <p>2/5/24: 2 Percocet tablets were signed out at 4 PM, 8 PM</p> <p>An additional sheet with the date range of 2/4/24 - 2/23/24:</p> <p>2/4/24: 2 Percocet tablets were signed out at 8 PM</p> <p>2/5/24: 2 Percocet tablets were signed out at 12 AM</p> <p>2/6/24: 2 Percocet tablets were signed out at 4 PM, 8 PM</p> <p>2/7/24: 2 Percocet tablets were signed out at 12:30 AM, 4 PM, 11 PM</p> <p>2/13/24: 2 Percocet tablets were signed out at 12:30 PM</p> <p>2/14/24: 2 Percocet tablets were signed out at 9 AM</p> <p>2/15/24: 2 Percocet tablets were signed out at 8 PM</p> <p>2/16/24: 2 Percocet tablets were signed out at 9 AM, 8 PM</p> <p>2/17/24: 2 Percocet tablets were signed out at 5 PM</p> <p>2/18/24: 2 Percocet tablets were signed out at 11 AM, 5 PM</p> <p>2/19/24: 1 Percocet tablet was signed out at 8 AM</p> <p>2/19/24: 2 Percocet tablets were signed out at 5 PM</p> <p>2/20/24: 2 Percocet tablets were signed out at 4 PM</p> <p>A review of the Medication Administration Record (MAR) for February 2024 revealed the resident was prescribed:</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Percocet Oral Tablet 5-325 MG (Oxycodone w/Acetaminophen) Give 1 tablet by mouth every 4 hours as needed for Pain (4-6) For moderate pain 4-6 on pain scale/ MD aware of drug side effects/ drug interactions -Order Date- 12/12/2023 -D/C Date- 06/16/2024</p> <p>Percocet Oral Tablet 5-325 MG (Oxycodone w/ Acetaminophen) Give 2 tablet by mouth every 4 hours as needed for Pain (7-10) For severe pain 7-10 on pain scale/ MD made aware of side effect and dosage -Order Date- 12/12/2023 -D/C Date- 02/21/2024</p> <p>A further review of the February 2024 MAR for the corresponding dates revealed the following:</p> <p>2/1/24: No pain level recorded, no pain evaluation, no signature noting that medication was administered.</p> <p>2/2/24: No pain level recorded, no pain evaluation, no signature noting that medication was administered.</p> <p>2/3/24: No pain level recorded, no pain evaluation, no signature noting that medication was administered at 7 AM, 12 PM, 4 PM, 8 PM.</p> <p>2/4/24: No pain level recorded, no pain evaluation, no signature noting that medication was administered at 8 PM</p> <p>2/5/24: No pain level recorded, no pain evaluation, no signature noting that medication was administered.</p> <p>2/6/24: No pain level recorded, no pain evaluation, no signature noting that medication was administered.</p> <p>2/7/24: No pain level recorded, no pain evaluation, no signature noting that medication was administered.</p> <p>2/13/24: No pain level recorded, no pain evaluation, no signature noting that medication was administered.</p> <p>2/14/24: No pain level recorded, no pain evaluation, no signature noting that medication was administered.</p> <p>2/15/24: No pain level recorded, no pain evaluation, no signature noting that medication was administered at 8 PM.</p> <p>2/16/24: No pain level recorded, no pain evaluation, no signature noting that medication was administered at 9 AM, 8 PM</p> <p>2/17/24: No pain level recorded, no pain evaluation, no signature noting that medication was administered at 5 PM.</p> <p>2/18/24: No pain level recorded, no pain evaluation, no signature noting that medication was administered.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2/19/24: No pain level recorded, no pain evaluation, no signature noting that medication was administered.</p> <p>2/20/24: No pain level recorded, no pain evaluation, no signature noting that medication was administered at 4 PM</p> <p>A review of the progress notes for the above corresponding dates did not include any additional documentation regarding Percocet administration for the aforementioned dates and times.</p> <p>2.) Resident #365 was not at the facility during the survey. A closed record review for Resident #365 was completed.</p> <p>A review of the Admission Record (an admission summary), revealed the resident had diagnoses which included, but were not limited to; opioid dependence, spinal stenosis (the narrowing of one or more spaces within your spinal canal), and fracture of the right tibia.</p> <p>A review of the comprehensive Minimum Data Set (MDS), an assessment tool, dated 11/13/23, which revealed the resident had a Brief Interview for Menal Status (BIMS) score of 15 out of 15, which indicated the resident's cognition was intact.</p> <p>A review of the resident's electronic medical record (EMR) revealed the resident had the following physician's orders:</p> <p>-Oxycodone HCl Oral Tablet 20 milligram (mg) (Oxycodone HCl) Give 20 mg by mouth every four (4) hours as needed for (severe pain 8-10) -Start Date: 11/13/23 -End Date: 12/26/23</p> <p>A review of the resident's Individual Patient's Controlled Drug Record for December 2023 revealed the following:</p> <p>A sheet with the date range of 11/23/23 - 12/3/23:</p> <p>12/1/23: 1 Oxycodone 20 mg signed out at 1:45 AM</p> <p>12/2/23: 1 Oxycodone 20 mg signed out at 12 AM</p> <p>An additional sheet with the date range of 12/4/23 - 12/12/23:</p> <p>12/11/23: 1 Oxycodone 20 mg signed out at 2:46 PM</p> <p>A review of the Medication Administration Record (MAR) for December 2023 revealed the resident was prescribed:</p> <p>Oxycodone HCl Oral Tablet 20 MG (Oxycodone HCl) Give 20 mg by mouth every 4 hours as needed for (severe pain 8-10) -Order Date- 11/13/2023 -D/C Date- 12/26/2023</p> <p>A further review of the December 2023 MAR for the corresponding dates revealed the following:</p> <p>(continued on next page)</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>12/1/23: No pain level recorded, no pain evaluation, no signature noting that medication was administered at 1:45 AM</p> <p>12/2/23: No pain level recorded, no pain evaluation, no signature noting that medication was administered at 12 AM.</p> <p>12/11/23: No pain level recorded, no pain evaluation, no signature noting that medication was administered at 2:46 PM.</p> <p>A review of the Progress Notes for the above corresponding dates did not include any additional documentation regarding Oxycodone administration.</p> <p>The facility provided the surveyor with an Investigation Summary for three staff: Licensed Practical Nurse (LPN) #1, LPN #2, and LPN #3. Under the Investigation Findings of each of the summaries, the following was noted: .Upon investigation, interviews and statements, alleged drug diversion was unsubstantiated . The investigation for LPN #1 also included an Employee Suspension Notice which revealed, [LPN #1] is being suspended pending investigation while facility investigates possible drug diversion. There was no evidence provided to the surveyor that the facility notified the NJDOH of the investigation related to a possible drug diversion.</p> <p>On 10/28/24 at 1:24 PM, during an interview with the surveyor that included Regional Director of Nursing (RDON) #1, RDON #2, the Director of Nursing (DON), the Licensed Nursing Home Administrator (LNHA) and the Regional Administrator (RLNHA), the surveyor asked if the concerns of the alleged drug diversion as referenced in the three Investigation Summaries had been reported to the NJDOH. RDON #1 stated, No, because we immediately ruled out the drug diversion issue through interviews with residents who all expressed relief of pain. We were also under the impression that the ombudsman had already informed the state.</p> <p>The surveyor reviewed the facility's undated Incident/Occurrence Investigation Procedure. Under the Policy Statement section the policy revealed, .3. All allegations of misappropriation of residents' property will be investigated . Further review of the policy did not reveal that the facility was to contact the NJDOH to report an alleged violation of misappropriation of resident property, per the regulation.</p> <p>NJAC 8:39-9.4</p> <p>NJAC 8:39-27.1(a)</p> <p>NJAC 8:39-29.7(c)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Respond appropriately to all alleged violations.</p> <p>48618</p> <p>COMPLAINT #: NJ172102</p> <p>Based on observations, interviews, records review, and review of other pertinent facility documentation, it was determined that the facility failed to thoroughly investigate an allegation of misappropriation of property for 1 of 3 residents (Resident #58) reviewed for personal property.</p> <p>This deficient practice was evidenced by the following:</p> <p>On 10/22/24 at 12:14 PM, the surveyor interviewed Resident #58 who reported that pain medications were always available when requested by the resident. The resident further stated that there was never a time when he/she did not receive pain medication when the resident asked for it.</p> <p>A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included, but were not limited to: borderline personality disorder, dorsalgia (a sensation of unpleasant feeling indicating potential or actual damage to some body structure felt in the back), and osteoarthritis (a degenerative disease that worsens over time, often resulting in chronic pain).</p> <p>A review of the quarterly Minimum Data Set (MDS), an assessment tool, dated 7/19/24, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 12 out of 15, which indicated that the resident's cognition was moderately impaired.</p> <p>A review of the electronic medical record (EMR) revealed the resident had the following physician's orders:</p> <p>-Percocet Oral Tablet 5-325 milligrams (mg) (Oxycodone w/ Acetaminophen) Give two (2) tablets by mouth every four (4) hours as needed for Pain (7-10) For severe pain 7-10 on pain scale/ MD made aware of side effect and dosage -Start Date: 12/12/23 -End Date: 02/21/24</p> <p>A review of the Individual Patient's Controlled Drug Record for February 2024 revealed the following:</p> <p>A sheet with the date range of 1/23/24 - 2/5/24:</p> <p>2/4/24: 2 Percocet tablets were signed out at 8 PM</p> <p>The Destroyed/Wasted Medication Doses section of the form was blank.</p> <p>An additional sheet with the date range of 2/4/24 - 2/23/24:</p> <p>2/4/24: 2 Percocet tablets were signed out at 8 PM</p> <p>The Destroyed/Wasted Medication Doses section of the form was blank.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of the Medication Administration Record (MAR) for February 2024 revealed the resident was prescribed:</p> <p>Percocet Oral Tablet 5-325 MG (Oxycodone w/ Acetaminophen) Give 2 tablet by mouth every 4 hours as needed for Pain (7-10) For severe pain 7-10 on pain scale/ MD made aware of side effect and dosage -Order Date- 12/12/2023 -D/C Date- 02/21/2024</p> <p>A further review of the February 2024 MAR for the corresponding dates revealed the following:</p> <p>2/4/24: No pain level recorded, no pain evaluation, no signature noting that medication was administered at 8 PM</p> <p>A review of the Progress Notes for the above corresponding dates did not include any additional documentation regarding Percocet administration for the aforementioned date and time.</p> <p>The facility provided the surveyor with an Investigation Summary for three staff: Licensed Practical Nurse (LPN) #1, LPN #2, and LPN #3. Under the Investigation Findings of each of the summaries, the following was noted: .Upon investigation, interviews and statements alleged drug diversion was unsubstantiated . The investigation for LPN #1 also included an Employee Suspension Notice which revealed that, [LPN #1] is being suspended pending investigation while facility investigates possible drug diversion.</p> <p>On 10/28/24 at 2:54 P.M., the surveyor interviewed the [NAME] President of Clinical Services (VPCS) #1, in the presence of Regional Director of Nursing (RDON) #2. The VPCS stated, The 2/4/24 duplicate dose at 8 PM was not investigated because it was not brought to our attention.</p> <p>The surveyor reviewed the facility's undated Incident/Occurrence Investigation Procedure. Under the Policy Statement section the policy revealed, .3. All allegations of misappropriation of residents' property will be investigated . The Procedure section further revealed, .Nursing or Social Services will conduct their initial investigation and review all pertinent documentation related to the event within 24 hours .</p> <p>NJAC 8:39-9.4</p> <p>NJAC 8:39-27.1(a)</p> <p>NJAC 8:39-29.7(c)</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>37547</p> <p>Based on interview, record review, and review of pertinent facility documents, it was determined that the facility failed to revise a resident's care plan with related goals and interventions each time the resident violated the facility's smoking policy.</p> <p>This deficient practice was identified for 1 of 5 residents (Resident #72) reviewed for smoking and was evidenced by the following:</p> <p>Refer to F689</p> <p>During the initial tour of the facility on 10/22/24 at 11:56 AM, the surveyor observed Resident #72 as he/she self-propelled in their wheelchair in the hallway. The resident's left upper extremity was flaccid (hung loosely) and the resident's left hand was edematous (swollen), without the use of a splint or sling to aid in supporting the affected extremity.</p> <p>A review of Resident #72's Admission Record, an admission summary, revealed the resident had diagnoses that included, but were not limited to: tobacco use, nicotine dependence, unspecified, uncomplicated, hemiplegia (paralysis of one side of the body) and hemiparesis (another term for hemiplegia) following cerebral infarction (stroke) affecting unspecified side.</p> <p>A review of Resident #72's comprehensive Minimum Data Set (MDS), an assessments tool, dated 9/30/24, revealed that the resident had a Brief Interview for Mental Status (BIMS) score of 9 out of 15, which indicated that the resident's cognition was moderately impaired. Further review of the MDS, under section J1300, indicated the resident was identified with current tobacco use.</p> <p>A review of Resident #72's individualized comprehensive care plan (ICCP) revealed an entry that was dated 12/27/21, with a revision date of 10/11/24, that indicated the resident was a smoker and used tobacco frequently and was not compliant with the smoking facility rules and policies. The goal indicated that the resident would safely continue to smoke without any issues (date initiated was 3/17/22, with a revision dated of 10/14/24). The interventions included, but were not limited to: Discussed where the smoking areas in the facility were, review contract annually, smoking assessment as needed, and, on 10/15/24, a care plan revision revealed that the SW (Social Worker) re-reviewed the smoking contract with resident.</p> <p>A review of Resident #72's Comprehensive Smoking Assessment, dated 9/27/24, revealed the following: The resident had cognitive loss, a dexterity problem, used the right hand for smoking, had a history of CVA (cerebral vascular attack, also known as a stroke), neurological disorder or chronic illness with residual altered sensation, and altered reflexes. Further review of the assessment, under Section E. Safety, indicated that the resident did not require adaptive equipment such as smoking apron (protective shield used to protect the clothing) or a cigarette holder. The assessment specified that the resident's cigarettes and lighters were in safe keeping.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/24/24 at 11:48 AM, the surveyor observed Resident #72 as he/she self-propelled in their wheelchair. The resident stated that he/she smoked at 11 AM, 2 PM, 4 PM, and 6 PM daily. The resident stated that the staff held their cigarettes and lighter. The resident's clothing was intact with no evidence of burn holes.</p> <p>On 10/25/24 at 11:15 AM, the surveyor observed Resident #72 in the smoking area in his/her wheelchair. The resident wore a scarf around his/her neck as a make shift sling to support his/her left upper extremity over their hooded sweatshirt. Smoking Aide (SA) #1 provided the resident with a cigarette and lit it for the resident.</p> <p>At that time, the surveyor noted that Resident #72 had a Band Aid on his/her right thumb. The resident held a cigarette in his/hand and the ash was very long. As the resident passed by SA #1 in his/her wheelchair while smoking, the ash fell down into his/her scarf and the front of the resident's hood. The resident quickly patted the area around their scarf and hood. The surveyor observed that the resident had a burn hole on the lower right portion of their hooded sweatshirt. When questioned about the hole, the resident stated, The hole was already there. Resident #72 then proceeded to pass his/her lit cigarette to Resident #137 in front of SA #1, and Resident #137 used the cigarette as a light source to light his/her cigarette rather than having SA #1 light it with the facility lighter. When the surveyor asked SA #1 if it were permissible for residents to share their cigarettes to light one another's cigarettes, SA #1 proceeded to reprimand the residents. When the surveyor asked SA #1 if she were required to intervene and offer direction to Resident #72 to flick the ash off of their cigarette before it became too long and fell on to his/her clothing, and SA #1 stated, I think he/she needs an apron. The surveyor then observed Resident #72 who had smoked the cigarette all of the way down to the filter, and the resident rolled the tip of the cigarette between their fingers. When the surveyor asked the resident how he/she extinguished the cigarette and where the cigarette butt was, the resident reached into the cup holder on their wheelchair that held a carton of juice. The surveyor then noted that the resident had placed the cigarette butt on the ground.</p> <p>At that time, Smoke Aide (SA) #2 was present and had helped to search for the resident's cigarette butt. SA #2 reached into the back of the resident's wheel chair and pulled out a cigarette. SA #2 stated that Resident #72 had a name brand cigarette in the back pocket of their wheelchair. SA #2 explained that the facility made their own generic cigarettes and did not provide residents with brand name cigarettes. SA #2 further stated, The resident was suspended last week because they found cigarettes and a lighter in the back of [his/her] chair. SA #2 stated that the resident put the cigarette on the ground when it was supposed to have been put in an ashtray. SA #2 stated, No one should have a light, but us. SA #2 further stated, All [he/she] had to do was ask us for a light. SA #2 stated, a cigarette was a personal item and should not be shared due to germs, and it was still a fire at the end of the day. SA #2 further stated, We try to keep all hazards to a minimum.</p> <p>On 10/25/24 at 11:40 AM, the surveyor interviewed Licensed Practical Nurse/Unit Manager (LPN/UM) #1 who stated that the Social Worker handled everything that had to do with smoking in the courtyard and informed staff when a smoking violation occurred.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/25/24 at 11:57 AM, the surveyor interviewed the Social Worker (SW) who stated that two weeks ago, Resident #72 was found with a cigarette and lighter in their possession coming outside to the courtyard and we immediately grabbed him/her and suspended the resident for two smoke breaks. She stated, I try to be lenient. The SW stated that the resident then tried to come after staff and was then suspended for one day. There was no documented evidence within the resident's electronic health record or ICCP that detailed the events described by the SW.</p> <p>On 10/25/24 at 1:39 PM, the surveyor requested all investigations related to Resident #72's smoking and was provided with a copy of an untitled document, dated 9/18/24, which indicated that it was Resident #72's first violation of Smoking and indicated that the resident's smoking privileges were suspended for one week. Further review of the document revealed that the resident's smoking privileges were stopped on 9/18/24 and resumed on 9/22/24. The document indicated that the resident refused to sign receipt. The facility also provided the surveyor with two smoking policies that were signed by the resident that were dated 4/19/23 and 5/3/24, and a notice that a Smoker's Meeting was held on 4/1/24.</p> <p>On 10/28/24 at 11:19 AM, the Regional Licensed Nursing Home Administrator (RLNHA) and the SW provided the surveyor with a timeline of events for Resident #72, dated 10/25/24. A review of the timeline revealed that the following:</p> <ol style="list-style-type: none"> 1. On 7/6, Resident was observed placing a name brand cigarette in his/her pocket. The residents room was searched and nothing was found. 2. On 7/12, found with lighter in his/her socks. Denied event. 3. On 8/23, had cigarettes behind his/her wheelchair. 4. On 9/18/24, was observed grabbing cigarette from the table. Denied event. First violation. 5. 10/6, observed trying to get cigarette from the ashtray. Got into altercation with another resident in the courtyard. Denied incident. Second violation. 6. 10/25, observed by surveyor with cigarette in the back of his/her wheelchair. Denied incident. Third violation. <p>There was no documented evidence that Resident #72's ICCP was updated when the resident demonstrated noncompliance with the facility smoking policy on 7/6, 7/12, 8/23, and 9/18/24.</p> <p>On 10/28/24 at 11:43 AM, the surveyor interviewed Registered Nurse (RN) #1 who stated that whoever found Resident #72 to be noncompliant with the facility smoking policy was responsible to update the resident's care plan.</p> <p>On 10/28/24 at 11:58 AM, the surveyor interviewed the MDS Coordinator (MDSC) who stated that it was a group effort at the facility to update resident care plans. The MDSC stated that the care plan should be updated however many times the resident had a violation in the smoking policy.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/28/24 at 1:47 PM, the surveyor interviewed the Regional Director of Nursing (RDON) in the presence of the survey team. The RDON stated that Resident #72's care plan was required to be updated after each smoking infraction. The RDON further stated that the care plan should clearly illustrate what staff needed to look for.</p> <p>On 10/29/24 at 9:39 AM, the surveyor interviewed the SW, in the presence of the survey team. The SW stated that the facility did not create an incident report for a resident harboring a lighter, just the smoking contract. The SW further stated that the care plan should have been updated after each occurrence.</p> <p>A review of the facility's Interdisciplinary Care Planning Protocol policy, undated, revealed the following:</p> <p>.Interdisciplinary Care Planning:</p> <p>Social Services provides overview of social history and needs</p> <p>Nursing provides overview of medical and nursing care regimes. Nursing provides input especially related to ADL (activities of daily living), skin, weights, and safety needs .</p> <p>.Problems established by the team with the resident/family input must be specific and individualized.</p> <p>NJAC 8:39-11.2 (e) 2</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37547</p> <p>Based on observation, interview, record review, and review of other pertinent documents, it was determined that the facility failed to provide adequate supervision during resident smoking sessions and consistently follow and implement the facility smoking policy to ensure the safety of all residents at the facility for 2 of 5 residents (Resident #72 and Resident #137) reviewed for smoking.</p> <p>This deficient practice was evidenced by the following:</p> <p>During the initial tour of the facility on 10/22/24 at 11:56 AM, the surveyor observed Resident #72 as he/she self-propelled in their wheelchair in the hallway. The resident's left upper extremity was flaccid (hanging loosely) and the resident's left hand was edematous (swollen), without the use of a splint or sling to aid in supporting the affected extremity.</p> <p>A review of Resident #72's Admission Record, an admission summary, revealed that the resident had diagnoses that included, but were not limited to: tobacco use, nicotine dependence, unspecified, uncomplicated, hemiplegia (paralysis of one side of the body) and hemiparesis (another term for hemiplegia) following cerebral infarction (stroke) affecting unspecified side.</p> <p>A review of Resident #72's comprehensive Minimum Data Set (MDS), an assessments tool, dated 9/30/24, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 9 out of 15, which indicated that the resident was moderately cognitively impaired. Further review of the MDS, under section J1300, indicated that the resident was identified with current tobacco use.</p> <p>A review of Resident #72's individualized comprehensive care plan entry, dated 12/27/21, with revision on 10/11/24, revealed the resident was a smoker and used tobacco frequently and was not compliant with the smoking facility rules and policies. The goal indicated that the resident would safely continue to smoke without any issues (date initiated was 3/17/22, with a revision dated of 10/14/24). The interventions included, but were not limited to: Discussed where the smoking areas in the facility were, review contract annually, smoking assessment as needed, and, on 10/15/24, a care plan revision revealed that SW (Social Worker) re-reviewed the smoking contract with resident.</p> <p>A review of Resident #72's Comprehensive Smoking Assessment, dated 9/27/24, revealed the following: The resident had cognitive loss, a dexterity problem, used the right hand for smoking, had a history of CVA (cerebral vascular attack, also known as stroke), neurological disorder or chronic illness with residual altered sensation, and altered reflexes. Further review of the assessment, under Section E. Safety, indicated that the resident did not require adaptive equipment such as smoking apron (protective shield used to protect the clothing) or a cigarette holder. The assessment specified that the resident's cigarettes and lighters were in safe keeping</p> <p>On 10/24/24 at 11:48 AM, the surveyor observed Resident #72 as he/she self-propelled in their wheelchair. The resident stated that he/she smoked at 11 AM, 2 PM, 4 PM and 6 PM daily. The resident stated that the staff held their cigarettes and lighter. The resident's clothing was intact with no evidence of burn holes.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/25/24 at 11:15 AM, the surveyor observed Resident #72 in the smoking area in his/her wheelchair. The resident wore a scarf around his/neck as a make shift sling to support his/her left upper extremity over their hooded sweatshirt. Smoking Aide (SA) #1 provided the resident with a cigarette and lit it for the resident.</p> <p>At that time, the surveyor interviewed Smoking Aide (SA) #1 who stated that she worked at the facility for one month. When the surveyor asked SA #1 to describe the process for the identification of residents who required smoking aprons, smoking holders, or smoking assistance she stated, They told me who smokes. She stated that the aides put smoke aprons on the residents and brought them down to smoke. When the surveyor asked SA #1 if she had a list of smokers with their level of smoking assistance identified to ensure compliance, and she stated there was no list. SA #1 stated that she knew who smoked which type of cigarettes. SA #1 further stated that the aides communicated any change in the resident's status. The surveyor pointed out to SA #1 that there were numerous cigarette butts on the ground in her direct vicinity. SA #1 stated, We have ashtrays. The residents know not to put their cigarettes out on the ground and we remind them.</p> <p>At that time, the surveyor noted that Resident #72 had a Band Aid on his/her right thumb. The resident held a cigarette in his/hand and the ash was very long. As the resident passed by SA #1 in his/her wheelchair while smoking, the ash fell down into his/her scarf and the front of the resident's hooded sweatshirt. The resident quickly patted the area around their scarf and the front of the hooded sweatshirt. The surveyor observed that the resident had a burn hole on the lower right portion of their hooded sweatshirt. When questioned about the hole, the resident stated, The hole was already there. Resident #72 then proceeded to pass his/her lit cigarette to Resident #137 in front of SA #1, and Resident #137 used the cigarette as a light source to light his/her cigarette rather than having SA #1 light it with the facility lighter, as required. When the surveyor asked SA #1 if it were permissible for residents to share their cigarettes to light one another's cigarettes, SA #1 proceeded to reprimand the residents. When the surveyor asked SA #1 if she were required to intervene and offer direction to Resident #72 to flick the ash off of their cigarette before it became to long and fell on to his/her clothing, and she stated, I think [he/she] needs an apron. The surveyor then observed the Resident #72 who had smoked the cigarette all of the way down to the filter, and the resident rolled the tip of the cigarette between their fingers. When the surveyor asked the resident how he extinguished the cigarette and where the cigarette butt was, the resident reached into the cup holder on their wheelchair that held a carton of juice. The surveyor then observed that the resident had placed the cigarette butt on the ground.</p> <p>At that time, Smoke Aide (SA) #2 was present and had helped to search for the resident's cigarette butt. SA #2 reached into the back of the resident's wheel chair and pulled out a cigarette. SA #2 stated that Resident #72 had put a name brand cigarette into the pocket of their wheelchair. SA #2 explained that the facility made their own generic cigarettes and did not provide brand name cigarettes. SA #2 stated, The resident was suspended last week because they found cigarettes and a lighter in the back of [his/her] chair. SA #2 stated that the resident put the cigarette on the ground when it was supposed to have been put in an ashtray. SA #2 stated, No one should have a light, but us. SA #2 further stated, All [he/she] had to do was ask us for a light. SA #2 stated, a cigarette was a personal item and should not be shared due to germs, and it was still a fire at the end of the day. SA #2 further stated, We try to keep all hazards to a minimum.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/25/24 at 11:40 AM, the surveyor interviewed Licensed Practical Nurse/Unit Manager (LPN/UM) #1 who stated that the SW handled everything that had to do with smoking in the courtyard and informed staff when a smoking violation occurred. LPN/UM #1 stated that she did not recall any smoking infractions within the past couple of weeks on the nursing unit. LPN/UM #1 stated that the facility stored the resident's cigarettes and lighters. LPN/UM #1 stated that if burn holes were noted on the resident's clothes, they informed the SW and evaluated the resident. LPN/UM #1 stated that if a smoking re-evaluation was needed, they notified the SW immediately.</p> <p>On 10/25/24 at 11:44 AM, the surveyor interviewed Registered Nurse (RN) #1 who stated that Resident #72 was very argumentative outside during smoke break with the Smoke Aide. RN #1 stated that she did not see any burn holes in the resident's clothing. RN #1 further stated that the Smoke Aide was there because they needed to monitor the residents. RN #1 stated that residents were not permitted to keep their cigarettes or lighter on them for their safety. RN #1 stated that the Smoke Aides should watch to ensure that the cigarette ashes did not get too long. RN #1 stated that residents were not permitted to pass their cigarettes to one another to light their cigarettes because a disease may be transmitted and for the safety of the resident.</p> <p>At that time, RN #1 further stated that she did not know why Resident #72 had a Band Aid on his/her thumb, but she would investigate and get an order for a treatment to the affected area. RN #1 stated that the facility had a container to put cigarettes out, but sometimes the residents had behaviors and threw it away instead, but that they were not allowed to because it could cause a fire. RN #1 stated that Resident #72 could smoke on their right side but needed assistance to light their cigarette.</p> <p>On 10/25/24 at 11:57 AM, the surveyor interviewed the SW who stated that the Smoke Aides informed her that there was an issue with Resident #72 smoking and the resident was now suspended. The surveyor asked the SW to go out to the smoking area with the surveyor. The SW stated that when a resident was admitted, the SW was in charge of the smoking evaluation and supervision in the courtyard. The SW explained that the resident was given a cigarette and light and if there were signs of motor skill deficit, they got an apron and showed the resident how to dispose of the cigarette. The SW stated that they should put the cigarette butt in the receptacle, not on the ground for safety.</p> <p>The SW further stated that two weeks ago, Resident #72 was found with a cigarette and lighter in their possession coming outside to the courtyard and they immediately grabbed him/her and suspended the resident for two smoke breaks. The SW stated, I try to be lenient. The SW stated that the resident tried to come after staff and was then suspended for one day. There was no documented evidence within the resident's electronic health record (EHR) that detailed the events described by the SW.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The SW further stated that residents should not light each other cigarettes for hygiene/infection reasons and the residents could get burned. The SW stated that the Smoke Aides should tell the resident to flick the ash and not allow it to get long because the ashes could be hot and the resident could get burned. The SW stated that the cigarette should be extinguished in the appropriate receptacle. The SW stated that the Smoke Aide should have paid attention and monitored what the residents were doing to avoid the resident putting the cigarette butt between their fingers and then placing the butt on the ground. The SW stated that the resident had a name brand cigarette in their possession and that needed to be investigated today, because sometimes visitors brought them in. The SW stated that the the aide should have notified them and made sure the resident was not burned when the ash fell on their clothes, because they needed to get an apron for that resident. The SW further stated, It will be addressed. Right now [he/she] is suspended. [He/she] will get an apron and take care of that. Residents having cigarettes is reported to me and we suspend smoking.</p> <p>At that time, the surveyor asked the Social Worker why there were so many cigarettes on the ground? The Social Worker stated, They should sweep before 9 AM and after lunch. I have not seen this many butts on the ground and it is a safety issue. The surveyor noted that there were cigarette butts mixed in with trash in the trash cans which included napkins, Styrofoam cups, plastic cups, and food items and the Social Worker stated that it was unsafe to have cigarette butts on the ground and in the trash cans with refuge. The Social Worker stated, It is a problem. It is a fire hazard.</p> <p>At that time, the surveyor asked the SW how Smoking Aide #1, who reportedly worked at the facility for one month, was expected to identify smokers and those residents who needed smoking aprons and the SW stated, We discussed who required an apron and any concerns. When the surveyor asked if there was a book that illustrated residents who needed aprons and those with identified safety concerns for the Smoking Aides to reference in the courtyard during smoking breaks, the SW stated, No, I notified everyone verbally.</p> <p>On 10/25/24 at 12:20 PM, the surveyor conducted a follow-up interview with Smoking Aide (SA) #1 who stated that she never saw residents put cigarette butts in the trash cans and was not sure when it happened. The surveyor showed SA #1 that there were multiple cigarette butts in the leaves that were on the ground and in every trash can on the courtyard. SA #1 stated, Sometimes they [the residents] get lazy and forget to throw it out. SA #1 stated that Resident #72, did it like that for attention, [he/she] did it anyway. SA #1 stated that she was supposed to redirect the resident when their ash became very long because it could fall on the resident's clothes and burn them.</p> <p>On 10/25/24 at 12:36 PM, the surveyor interviewed the Director of Nursing (DON), in the presence of the survey team. The DON stated that if an ash were to drop on the resident's clothing, the aide should go and assist the resident. The DON stated that residents should not light cigarettes off one another for safety reasons. The DON stated that the resident should not extinguish their cigarette with their fingers because the facility did not want them to burn themselves. The Regional Licensed Nursing Home Administrator (RLNHA) was present and stated that all cigarettes should be placed in the noncombustible trash can or an ashtray. The RLNHA stated that cigarette butts should not be placed on the ground or in the leaves. The RLNHA stated that the yard was cleaned right after every smoke session and could not explain why the yard had not appeared to have been swept after the 9 AM smoking break, prior to the 11 AM smoking observation, or immediately after the 11 AM smoking break.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/25/24 at 1:39 PM, the surveyor requested all investigations related to Resident #72's smoking and was provided with a copy of an untitled document, dated 9/18/24, which indicated that it was Resident #72's first violation of smoking and indicated that the resident's smoking privileges were suspended for one week. Further review of the document revealed that the resident's smoking privileges were stopped on 9/18/24 and resumed on 9/22/24. The document indicated that the resident refused to sign receipt. The facility also provided the surveyor with two signed smoking policies dated 4/19/23 and 5/3/24 that were signed by the resident, and a notice that a Smoker's Meeting was held on 4/1/24.</p> <p>On 10/28/24 at 10:42 AM, the surveyor reviewed a Nursing Progress Note in Resident #72's EHR, dated 10/25/24 at 2:54 PM, that was written by RN #1, which indicated that the resident's right thumb finger tips were noted with small dried cracked skin 0.5 (no unit of measurement used) x 0.2 x 0. Resident's right hand dry with a callus to the palm. The progress note further indicated the resident was non-compliant with proper wheelchair propulsion, refused a complete body assessment, a pain assessment was done and resident denied pain when asked, and a treatment to right thumb finger tips.</p> <p>On 10/28/24 at 1:47 PM, the surveyor interviewed the Regional Director of Nursing (RDON), in the presence of the survey team. The RDON stated that they had a smoking binder and it detailed who required a smoking apron and was kept out in the smoking area. The surveyor informed the RDON that it was confirmed that there was no smoking binder present at the time of the smoking observation on 10/25/24. The RLNHA stated that the SW ran the smoking program for [AGE] years and could speak to the fact that she did not voice prior resident infractions of Resident #72 having cigarettes and lighters in the building or any investigations related to such infractions. The surveyor asked why the two smoke aides who monitored a multitude of residents during the smoking observation failed to ensure that residents were properly monitored and cigarette butts were not placed in the ashtrays or proper receptacles and he stated, We have eighty three smokers, and they are non-compliant.</p> <p>On 10/28/24 at 9:39 AM, the surveyor conducted a follow-up interview with the SW, in the presence of the survey team. The SW stated that she was a little upset when originally interviewed by the surveyor, but that there was a smoking binder that was kept in a closet in the door of the copy room, and it is listed who needs smoking aprons and who has smoking suspensions. The Licensed Nursing Home Administrator (LNHA) stated that the binder was kept with the cigarettes and smoking supplies. The SW stated that SA #1 knew about the binder. The surveyor reiterated that both SA #1 and the SW stated when previously interviewed that there was no binder, and communications between the SA and the SW were conducted verbally. The SW then stated, I do not know what she [SA #1] was thinking.</p> <p>A review of the facility's Smoking policy, revised 5/24, revealed the following:</p> <p>.Appropriate receptacles must be used at all times.</p> <p>Residents are not permitted to use, have or store cigarettes, cigars, matches, or lighters without any exceptions. For the safety of all the residents smoke in groups a, b, c, and 4. Group 4 is a closely monitored group.</p> <p>Residents who have smoking contracts agree to the facility policy. Residents are not permitted to keep any smoking items. Visitors and family members are asked not to provide lighters, matches and cigarettes or to light cigarettes for any residents. Cigarettes should be provided to the smoke aide, social worker, or Nursing Supervisor for distribution as appropriate</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>.Residents who do not adhere to the smoking contract will lose their smoking privileges. See schedule infractions</p> <p>a. First Offense-Loss of all smoking privileges for a week, followed by loss of independent status.</p> <p>b. Second Offense-Loss of all smoking privileges for 2 weeks, followed by loss of independent status.</p> <p>c. Third Offense-Loss of smoking privileges for a month, followed by loss of independent status.</p> <p>d. Fourth Offense-Loss of smoking privileges permanently. 30-day discharge.</p> <p>The following are reasons for smokers to get their smoking privileges suspended</p> <p>i. Noncompliance of facility rules and regulations related to smoking in non-designated areas.</p> <p>ii. Smoking in an area of the facility and its campus that is not a designated smoking area.</p> <p>iii. Providing or asking others for cigarettes and/or lighting materials.</p> <p>iv. Having in their possession any smoking paraphernalia .</p> <p>The surveyor reviewed SA #1's undated signed Job Description which revealed the following:</p> <p>.The responsibilities of the smoking aide are to ensure that all residents are safe while smoking.</p> <p>.Provide cigarettes for and light cigarettes for all residents.</p> <p>The Aide will assure that all residents when needed will wear appropriate smoking aprons.</p> <p>.You must maintain the area clean and organized.</p> <p>You must report an issues immediately. You will call Social Worker or call the nursing Supervisor a [sic.] soon as possible.</p> <p>.The smoking aide will maintain the courtyard area clean sweeping periodically, emptying the ashtrays.</p> <p>.Residents are only allowed one cigarette at a time.</p> <p>.You will ensure the Courtyard rules are followed.</p> <p>A review of an untitled document signed by SA #1 on 9/4/24, revealed the following:</p> <p>Pre-Smoke Break Preparation:</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>1. Verify Resident Eligibility:</p> <p>Confirm that each resident scheduled for the break is permitted to smoke.</p> <p>2. Gather and Check Supplies:</p> <p>Ensure that you have the pre-rolled cigarettes, a lighter/matches, ashtrays, and any other needed supplies</p> <p>.Safety Checklist During the Smoke Break:</p> <p>.Maintain Supervision:</p> <p>Stay close to the residents and observe them throughout the smoke break. Be vigilant for signs of distress, such as coughing, shortness of breath, or unsteady hands.</p> <p>Please be on the lookout for residents who are violating any of the guidelines set forth in the resident's smoking contracts.</p> <p>Use of Smoking Materials:</p> <p>Light the cigarettes for the residents.</p> <p>Ensure that ashtrays are used for all ash disposal to prevent accidental fires</p> <p>.End of Smoke Break Procedures:</p> <p>1. Extinguish and Dispose Properly:</p> <p>Make sure each cigarette is completely extinguished and disposed of safely in the designated ashtray or disposal area</p> <p>.Inspect Smoking Area:</p> <p>Do a final check of the smoking area to ensure no smoldering butts or ashes are left.</p> <p>NJAC 8:39-33.1(d), 27.1(a)</p>

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>41072</p> <p>Based on observation, interview, review of medical records and other facility documentation, it was determined that the facility failed to complete the dialysis communication book for a resident on dialysis (a treatment that replicates the kidney's function and cleans the waste from blood for individuals with kidney disease or kidney failure).</p> <p>This deficient practice was identified for 1 of 2 residents (Resident # 61) reviewed for dialysis and was evidenced by the following:</p> <p>On 10/23/24 at 9:14AM, the surveyor reviewed the medical records for Resident #61.</p> <p>A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included, but were not limited to: dependence on renal dialysis.</p> <p>A review of the resident's comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 8/23/24, included the resident had a Brief Interview for Mental Status (BIMS) score of 8 out of 15, which indicated that the resident's cognition was moderately impaired.</p> <p>A review of the resident's individual comprehensive care plan (ICCP) included a focus area, dated 8/17/224, that the resident received Dialysis treatment three times a week. Interventions included: the resident will have dialysis on the following days of the week: Tuesday, Thursday, Saturday.</p> <p>A Review of the Order Summary report (OSR), dated as of 10/25/24, included the following physician's orders (PO):</p> <p>A PO, dated 8/18/24, to check hemodialysis binder upon return from dialysis on Tuesdays, Thursdays, Saturdays, note any recommendations every shift for monitoring.</p> <p>A PO, dated 9/17/24, for dialysis treatment three (3) times a week on Tuesdays, Thursdays, and Saturdays.</p> <p>On 10/24/24 at 12:52 PM, the surveyor reviewed Resident # 61's Dialysis Communication Book which included Dialysis Communication Tool forms for the months of August, September, and October 2024 and revealed the following:</p> <p>On 8/20/24 the dialysis center did not complete their portion of the Dialysis Communication Tool.</p> <p>On 9/24/24 the dialysis center did not complete their portion of the Dialysis Communication Tool.</p> <p>On 10/12/24 the dialysis center did not complete their portion of the Dialysis Communication Tool.</p> <p>A review of the progress notes revealed the following nurses notes (NN):</p> <p>A NN, dated 8/20/24 at 10:37AM, which included that the resident returned form dialysis.</p> <p>(continued on next page)</p>

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A NN, dated 9/24/24 at 5:43AM, which included that the resident was out for dialysis.</p> <p>A NN, dated 10/12/24 at 4:55 AM, which included that the resident left for dialysis.</p> <p>A further review of the progress notes, from 8/17/24 through 10/25/24, did not include any documentation that the nurses contacted the dialysis center or obtained the post dialysis information for the following dates: 8/20/24, 9/24/24, and 10/12/24.</p> <p>On 10/25/24 at 9:19 AM, the surveyor observed Resident # 61 awake and alert lying in bed. Resident #61 stated that he/she goes to dialysis and sometimes has problems with the transportation.</p> <p>On 10/25/24 at 9:20 AM, the surveyor interviewed Registered Nurse (RN #2) who stated that the dialysis communication binder would be sent with the resident on dialysis days. The nurse would complete the top section of the form and the dialysis center would complete the bottom section. When the resident returned from dialysis, the nurse would check the communication binder and if the dialysis center did not complete their section, the nurse should call the dialysis center and obtain a report and document the information in the nurses' notes. RN #2 further stated that it was important that the communication tool was filled out completely because it is the facility's communication with dialysis. The dialysis center would communicate on the form if there were any new medications, medications that were administered at dialysis, or any recommendations for fluid restrictions.</p> <p>On 10/25/24 at 9:33 AM, the surveyor interviewed Licensed Practical Nurse/Unit Manager (LPN/UM) #2 who stated that nurses completed the top part of the communication tool form prior to going to dialysis, and the dialysis center would complete the bottom section after dialysis. If the dialysis center did not complete their section when the resident returned from dialysis, then the nurse should call the dialysis center and either fax the form to the center for completion or obtain a report and document the information on the form or in the nurses' notes.</p> <p>On 10/28/24 at 10:05 AM, the surveyor interviewed the Director of Nursing (DON) who stated that if the dialysis center did not complete their section of the communication tool form, the nurse would call the dialysis center and either obtain a report via the phone or fax the form to the center to be completed and faxed back to the facility. The DON stated that it was important that the communication tool form was completed by the dialysis center post dialysis so that the nurses knew what medications were given at dialysis, the pre and post weight of the resident, and if there were any new recommendations or orders.</p> <p>A review of the facility's Dialysis Management (Hemodialysis) policy, undated, included to complete the Dialysis Communication Tool before and after dialysis and following up on any special instructions from the dialysis center.</p> <p>NJAC 8:39-27.1(a)</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>40041</p> <p>Based on interview, record review, and review of other facility documentation, it was determined that the facility failed to administer medication in accordance with the physician's orders.</p> <p>This deficient practice was identified for 1 of 7 residents (Resident #110) reviewed for unnecessary medications and was evidenced by the following:</p> <p>According to the Admission Record, an admission summary, Resident #110 had diagnoses including, but not limited to: paroxysmal atrial fibrillation (an irregular, often heart rate that commonly causes poor blood flow.)</p> <p>A review of the Physician's Orders (PO) revealed a physician's order dated 5/27/24 for Cardizem oral tablet 120 milligram give one tablet by mouth three times a day for atrial fibrillation related to paroxysmal atrial fibrillation, hold for systolic blood pressure less than 130, to be crushed into pudding or applesauce.</p> <p>A review of the June 2024 and July of 2024 Medication Administration Record (MAR) revealed the referenced medication was administered by nursing staff when the resident's systolic blood pressure (SBP) [the first number in your blood pressure reading] was below 130 mm HG (a unit of measurement used to record blood pressure) on the following dates:</p> <p>On 6/1/24 at 1:00 PM with a SBP of 122 mm/HG</p> <p>On 6/3/24 at 1:00 PM with a SBP of 119 mm/HG</p> <p>On 6/17/24 at 5:00 PM with a SBP of 120 mm/HG</p> <p>On 6/18/24 at 5:00 PM with a SBP of 105 mm/HG</p> <p>On 6/23/24 at 9:00 AM with a SBP of 126 mm/HG</p> <p>On 6/23/24 at 5:00 PM with a SBP of 118 mm/HG</p> <p>On 6/27/24 at 1:00 PM with a SBP of 115 mm/HG</p> <p>On 6/28/24 at 1:00 PM with a SBP of 96 mm/HG</p> <p>On 7/1/24 at 1:00 PM with a SBP of 124 mm/HG</p> <p>A review of the pharmacy consultant recommendation, dated 5/28/24 and signed by nursing on 6/21/24, revealed, medication error (s) noted. Cardizem is not always held as required by the physicians hold order. After the pharmacy recommendation, nursing staff continued to administer Cardizem to Resident #110 Cardizem outside of the SBP parameters ordered by the physician.</p> <p>(continued on next page)</p>

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/29/24 at 9:39 AM, the surveyor interviewed the Director of Nursing (DON) who stated that the pharmacy recommendations were given to the unit manager and then the provider would be made aware for changes to be made according to the pharmacy recommendation.</p> <p>During the same interview, Regional Director of Nursing (RDON) #2 stated the directions on the medication order should be followed and the nurse should notify the physician if they need to.</p> <p>A review of the facility's Administering Medications policy, reviewed 5/18/24, revealed Medications shall be administered in a safe and timely manner, and as prescribed, and, must be administered in accordance with the physician orders, including any required time frame.</p> <p>NJAC 8:39-29.2(d)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40041</p> <p>Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to a.) store food in a manner to prevent food-borne illness, b.) maintain the kitchen equipment in a sanitary manner to prevent contamination from foreign substances and potential for the development a food borne illness, and c.) label all food items in the refrigerator.</p> <p>This deficient practice was identified in the facility kitchen and in 1 of 1 nursing unit pantry and was evidenced by the following:</p> <p>On [DATE] at 9:39 AM, the surveyor, accompanied by the Food Service Director (FSD), observed the following in the kitchen:</p> <p>1.) In the refrigerator identified as the walk-in cooler, a cluster of bok choy and lemongrass was noted on the shelf. Both items were dated [DATE]. At that time, the surveyor interviewed the FSD who stated that he was unsure of when the items needed to be discarded.</p> <p>2.) In the food preparation area, a heavy duty commercial blender base was observed with hardened food stain and a moderate amount of discoloration. At that time, the surveyor interviewed the FSD who stated that the blender should be clean. He further stated that the facility planned on purchasing a new blender.</p> <p>3.) When the surveyor opened the pellet heater (used to warm pellets - a plate-like device used to keep foods hot) door, the interior sides and multiple pellets were noted with small food particles and a moderate amount of thick brownish sticky-like residue. At that time, the surveyor interviewed the FSD who stated that the pellets were last used for breakfast ([DATE]). When asked if the pellets had been cleaned, the FSD stated, not yet, they are going to do that right now. When asked the process for when the pellets were returned to the kitchen, the FSD explained the pellets went to the dish room, were cleaned, allowed to be air dried, and then they were returned to the pellet heaters to get ready for the next meal.</p> <p>4.) The surveyor requested to see the dish washer temperature and chlorine log. The FSD provided the surveyor with the log which revealed the Dish Machine Ware Washing- Low Temperature log for the month of October was incomplete; the lines to record the temperature and chlorine level for [DATE]th, 21st, and 22nd were blank for breakfast, lunch, and dinner. At that time, during an interview, Dietary Aide (DA) #1 stated the temperature and chlorine levels were tested before and after he started the wash. I make sure the machine is working right. When asked if the temperature and chlorine levels were checked today ([DATE]), DA#1 replied, Yes. He further stated that the results were not documented in the log. At that time, the FSD stated that the temperature and chlorine levels on ,d+[DATE], ,d+[DATE], and ,d+[DATE] should have been completed and documented in the log.</p> <p>On [DATE] at 10:29 AM, the surveyor, accompanied by the FSD, observed the following in the food storage supply area located in the basement:</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>5.) There were two (2) boxes containing multi packages of barley from two (2) different manufacturers. The packages in Box #1 had a best by date of [DATE]. The surveyor observed bugs crawling inside the packages. Box #2 did not have an expiration date on the individual packages or on the outside of the box. On the same shelf, there was also a box containing multiple packages of green split peas with the expiration date of [DATE]. At that time, the surveyor interviewed the FSD who confirmed the surveyor's findings and discarded the expired barley and green split peas. The FDS stated that he was responsible for ensuring that there were no expired foods on the shelf. The FSD further stated, everything should be labeled with a receive date and discarded after six (6) months.</p> <p>On [DATE] at 12:14 PM during an interview with the surveyor, the Licensed Nursing Home Administrator (LNHA) stated that the pellets should be cleaned after every meal. When asked how often the dish machine solution should be tested , the LNHA stated, they do it every day. He further stated that the dish machine log should be completed and, I constantly audit the logs to make sure they fill them in.</p> <p>On [DATE] at 9:03 AM, the surveyor, accompanied by Certified Nursing Aide (CNA) #1, observed the following unlabeled food items in the refrigerator/freezer designated for resident food in the B Wing pantry:</p> <p>6.) In the refrigerator:</p> <ul style="list-style-type: none"> -Plastic container with soup -Two (2) cups of juice -A can of soda -Bottle of strawberry banana juice -Potato chips <p>7.) In the freezer:</p> <ul style="list-style-type: none"> -An insulated travel cup -Ice cream <p>At that time, CNA #1 stated that all of the items in the refrigerator belonged to the residents. She further stated that staff members brought items from other units and placed them in the refrigerator and CNA #1 does not know what food belongs to each resident. She also stated that each food item should be labeled accordingly.</p> <p>On [DATE] at 9:18 AM, Regional Director of Nursing (RDON) #2 confirmed the surveyor's findings. She stated that all items in the refrigerator should have been labeled with the resident's name and the use by date.</p> <p>Review of the facility's Subject: Labeling and Dating Procedure Implemented in the Dietary Department policy, undated, revealed the following:</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>1. Food items, as appropriate will be labeled and dated by dietary staff using the facility labeling system, and the food service director/designee will oversee labeling and dating.</p> <p>2. All perishable products will be dated using the date of production. The dated product will be used up to and including the 3rd day from the date of production unless otherwise marked. All products after this date will be discarded.</p> <p>3. Perishable foods are checked for spoilage by the FSD/designee.</p> <p>4. Dated products are checked for expiration by the FSD/designee.</p> <p>Review of the facility's Dish Machine policy, reviewed/revise [DATE], revealed. The kitchen will wash, rinse and sanitize after each meal service. Procedure: Staff will scrape waste off dishes and trays into food waste container. Rinse dishes thoroughly into scrap sink. Remove all dishes and inspect for cleanliness and dryness. Dishwasher staff will monitor and record dish machine temperatures to assure compliance for wash and rinse cycles. Low Temp Machine (Wash 120 degrees F, rinse no higher than 150 degrees F) Must use chlorine test strip prior to and during use and must read ,d+[DATE] PPM. FSD or designee will monitor temp. log and PPM readings prior to each usage for compliance.</p> <p>NJAC 8;d+[DATE].2(g)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>41260</p> <p>Based on observations, interviews, record review, and review of facility documents, it was determined that the facility failed to maintain proper infection control practices for donning (putting on) appropriate Personal Protective Equipment (PPE) prior to providing care to a resident who was on Enhanced Barrier Precautions (EBP) for 1 of 1 resident (Resident #138) reviewed for pressure ulcers.</p> <p>This deficient practice was evidenced by the following:</p> <p>On 10/24/24 at 10:26 AM, the surveyor reviewed the electronic medical record for Resident #138.</p> <p>A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included, but were not limited to: pressure-induced deep tissue damage of right ankle and pressure-induced ulcer of left heel unstageable.</p> <p>A review of the comprehensive Minimum Data Set (MDS), an assessment tool, dated 9/18/24, included the resident had a Brief Interview for Mental Status (BIMS) score of 9 out of 15, which indicated the resident's cognition was moderately impaired. Further review of the MDS revealed the resident had multiple pressure ulcers that were not present upon the resident's admission to the facility.</p> <p>A review of the individualized comprehensive care plan (ICCP) included a focus area, initiated 08/19/24, that the resident was on EBP during high contact resident care activities related to skin alterations. Interventions included that staff must wear a gown and gloves during wound care and that staff should don PPE before care.</p> <p>A review of the Order Summary Report (OSR), dated as of 10/25/24, included the following physician's orders (PO):</p> <p>A PO, dated 08/19/24, for Enhanced Barrier Precautions (EBP) adherence during high contact resident care activities. Must wear gown and gloves during: . wound care. DON/DOFF and cleanse hands before and after care.</p> <p>On 10/24/24 at 12:14 PM, the surveyor observed Resident #138's doorway which revealed a small pink flower next to the resident's name. There was no other indication that the resident was on EBP and there was no PPE supply bin outside the resident's room.</p> <p>On 10/25/24 at 11:07 AM, the surveyor observed a wound care treatment performed by Registered Nurse (RN#2). RN#2 reviewed the treatment order, washed her hands, gathered the treatment supplies, and entered Resident #138's room without donning PPE. The RN then donned gloves, removed the old wound dressing from the resident's left heel, removed her gloves, washed her hands, donned new gloves, and applied the treatment to the resident's left heel. The RN did not don a gown when she performed the wound care treatment.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/25/24 at 11:46 AM, immediately after the wound treatment observation, the surveyor interviewed RN #2 who stated residents with wounds were on EBP and that staff must wear PPE which consisted of a gown and gloves when providing wound care. The RN further stated the flower next to the resident's name at the doorway indicated the resident was on EBP, but that Resident #138 should have had a PPE supply bin outside of the room, which was why the RN did not remember to don PPE prior to entering the room. The RN explained that it was important to wear the correct PPE for residents on EBP to protect the resident and staff from any pathogens.</p> <p>On 10/25/24 at 11:39 AM, the surveyor interviewed the Director of Nursing (DON) who stated that residents with wounds were on EBP and that staff must wear PPE which consisted of a gown and gloves when providing wound care. The DON further stated that a flower next to the resident's name at the doorway indicated the resident was on EBP and that there should be a PPE supply bin outside the resident's room. The DON explained that PPE should be donned at the door prior to entering the room to protect the resident. At that time, the surveyor informed the DON of the wound care treatment performed by RN #2 and the DON confirmed that RN #2 should have worn a gown during the wound care treatment.</p> <p>A review of the facility's Enhanced Barrier Precautions (EBP) policy, dated 4/1/24, included, EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs [multi-drug resistant organisms] to staff hands and clothing.</p> <p>NJAC 8:39-19.4(a); 27.1(a)</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>49509</p> <p>Complaint #: NJ175570</p> <p>Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to ensure a safe and sanitary physical environment in the central supply room.</p> <p>This deficient practice has the potential to affect 3 of 3 nursing units and was evidenced by the following:</p> <p>On 10/23/24 at 12:25 PM, the surveyor conducted a tour of the facility's basement, in the presence of the facility's Regional Licensed Nursing Home Administrator (RLNHA) and the staff member in charge of Central Supply. At that time, the surveyor entered the Central Supply room and observed, adhered on the wall board ceiling to the right of the doorway near the pipes, a black substance approximately 24 inches in length.</p> <p>On 10/23/24 at 1:00 PM, the surveyor revisited the Central Supply room and observed the RLNHA and the Maintenance Assistant (MA) present in the room. The MA had a pitcher of white paint with a brush and was applying the white paint over the black substance on the ceiling. At that time, the surveyor interviewed the RLNHA who stated, it was dirt on the ceiling.</p> <p>On 10/23/24 at 1:10 PM, the surveyor interviewed the staff member in charge of Central Supply who stated she was unaware of the black substance that was observed on the ceiling. She further stated the prior staff had resigned and she was covering.</p> <p>On 10/23/24 at 1:15 PM, the surveyor interviewed the Maintenance Director who stated that he was unaware that there was a black substance on the ceiling in the Central supply room.</p> <p>On 10/28/24 at 1:34 PM, the RLNHA, in the presence of the LNHA, Director of Nursing (DON), Regional DON (RDON) #1, RDON#2 and the survey team, stated that it was scud and dirt on the ceiling and it came right off. He further stated that the ceiling was cleaned and then painted over after surveyor inquiry.</p> <p>The facility was unable to provide a policy related to maintaining a safe and sanitary physical environment. The RLNHA stated they followed their Infection Control policy.</p> <p>NJAC 8:39-31.2(e)</p>