STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315263	A. BUILDING 01 B. WING	03/31/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 03/30/2022 and 03/31/2022 and The Palace Rehabilitation and Care Center was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. The Palace Rehabilitation and Care Center is a two (2) story, Type V Protected building that was built in June 1988. The facility is divided into 10 smoke zones.	K 000		
K 241 SS=D	Number of Exits - Story and Compartment CFR(s): NFPA 101 Number of Exits - Story and Compartment Not less than two exits, remote from each other, and accessible from every part of every story are provided for each story. Each smoke compartment shall likewise be provided with two distinct egress paths to exits that do not require the entry into the same adjacent smoke compartment. 18.2.4.1-18.2.4.4, 19.2.4.1-19.2.4.4 This REQUIREMENT is not met as evidenced by:	K 241		5/27/22

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

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

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K 241	Continued From page 1 Based on observation and interview on 03/30/2022, in the presence of facility management, it was determined that the facility failed to ensure that 2 acceptable exits, remote from each other, were provided for [redacted] floor/story of the building. This deficient practice was evidenced by the following: During the survey entrance at 8:50 AM, the surveyor ask the Administrator and Director of Maintenance (DOM) does the facility have any waivers. The DOM told the surveyor that the facility had a Fire Safety Evaluation Systems (FSES) for the [redacted] floor for having one acceptable exit from the [redacted] floor. The surveyor toured the [redacted] floor and observed one acceptable exit from the [redacted] floor. This exit consisted of a single stairway to the main floor. At that time, the surveyor further observed one business staff members occupying the [redacted] floor offices. When interviewed, the DOM and Regional Administrator (RA), stated that residents were not permitted in this section of the building and that only authorized personnel had the code to unlock the stairway door. In addition, the [redacted] floor was used for the business and medical records offices and were for staff use only. Also, the [redacted] floor and exit stairway were protected by the fire alarm system and an automatic fire sprinkler system. The RA and DOM further stated that staff would be in-serviced on the hazard of having only one exit from the [redacted] floor at orientation and annually thereafter, and that the facility would conduct at least one fire drill on the [redacted] floor each year.	K 241	Element 1 Facility requesting a TIME LIMITED WAIVER for k241 with an estimated completion date of 12/7/2023 We are proposing to provide a new second means of egress from the existing [redacted] story. This will take time as we need to retain an architect, draw up plans, submit to Division Community Affairs, Department of Health and local building/ zoning departments for approval and then do the actual construction. Therefore, we are requesting a time limited waiver Element 2 All staff that use the business office on the [redacted] floor have the potential to be affected. The [redacted] floor is not a resident care area, and it is not accessible to residents or visitors. Element 3 Facility provides no patient access to the [redacted] floor. All staff that have access will be trained to know where the exit is. Battery operated smoke detection will be installed for all spaces on the [redacted] floor, including closets, bathrooms etc. This is in addition to any wired-in smoke detection already installed in the corridor. Element 4 Maintenance Director will conduct monthly	

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K 241	Continued From page 2 The RA and DOM, were informed that the facility is required to have a Fire Safety Evaluation System (FSES) and was provided a document "instructions for past wavered citations." The surveyor informed the Administrator of the finding at the Life Safety Code survey exit on 03/31/22. NJAC 8:39-31.1(c), 31.2(e)	K 241	checks of battery-operated smoke detectors including closets, bathrooms etc. on the [redacted] floor This is in addition to any wired-in smoke detection already installed in the corridor. Maintenance Director will report all Findings and corrective actions taken at the quarterly Qapi committee meeting.	
K 291 SS=D	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 03/30/2022, in the presence of facility management, it was determined that the facility failed to provide a functioning battery backup emergency light above the emergency generator's transfer switch, independent of the building's electrical system and emergency generator, in accordance with NFPA 101:2012 - 7.9, 19.2.9.1. This deficient practice was evidenced by the following: On 03/30/2022 starting at 9:02 AM with the facility's Regional Administrator (RA) and Director of Maintenance (DOM), a tour of the building was conducted. During the tour at 9:57 AM, an inspection inside the main Electrical Room, where the emergency generator and generator's transfer switch is located, was performed. The surveyor	K 291	Element 1 The battery back up emergency light located inside the main electrical room was replaced with a new battery back up emergency light fixture. Element 2 All residents have the potential to be affected by this practice Element 3 The maintenance Director added the battery back up emergency light test, to the weekly emergency generator log sheet.	5/5/22

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K 291	Continued From page 3 observed inside the room a battery back-up emergency light. At that time, a request was made of the DOM to conduct a test of the battery backup emergency light. When the DOM performed the test pushing the test button, the light did not function. The findings were verified and confirmed by the RA and DOM during the observations. The surveyor informed the Administrator of the finding at the Life Safety Code survey exit on 03/31/22. NJAC 8:39-31.2(e) NFPA 101:2012 - 19.2.9.1, 7.9	K 291	Element 4 The Maintenance Director will conduct the battery back up emergency light test weekly with the emergency generator. The maintenance Director will report all findings to the administrator and QA committee monthly for one quarter and then randomly or as needed based on the recommendations of the QA committee after the quarter.	
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A	K 321		5/5/22

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K 321	Continued From page 4 a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 03/30/2022, in the presence of facility management, it was determined that the facility failed to provide fire barriers with a one-hour fire resistance rating to hazardous areas in accordance with NFPA 101, 2012 Edition, Section 19.3.2.1, 19.3.2.1.3, 19.3.2.1.5, 19.3.6.3.5, 19.3.6.4, 8.3, 8.3.5.1, 8.4, 8.5.6.2 and 8.7. This deficient practiced was evidenced by the following: On 03/30/2022 starting at 9:02 AM with the facility's Regional Administrator (RA) and Director of Maintenance (DOM), a tour of the building was conducted. During the tour at 11:47 AM, an inspection inside the boiler room on █-Wing unit was performed. The surveyor observed inside the boiler room, that the ceiling had penetrations in the plaster ceiling as follows: 1) One penetration opening in the ceiling approximately 6" by 4". 2) One penetration opening in the ceiling approximately 4" by 10". 3) One penetration opening in the ceiling	K 321	Element 1 The observed penetrations inside the boiler room on █ wing were replastered leaving no penetrations as follows, 1) One penetration opening in the ceiling approximately 6" by 4", were replastered leaving no penetrations 2) One penetration opening in the ceiling approximately 4" by 10",were replastered leaving no penetrations 3) One penetration opening in the ceiling approximately 3" by 8",were replastered leaving no penetrations 4) One penetration that was approximately 1- 1/2", in diameter were replastered leaving no penetrations Element 2 All residents have the potential to be affected by this practice	

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K 321	Continued From page 5 approximately 3" by 8". 4) One penetration that was approximately 1-1/2" in diameter. This condition would allow fire, smoke and poisonous gases to pass from the boiler room into the attic and spread to other parts of the facility. The findings were verified and confirmed by the RA and DOM during the observations. The surveyor informed the Administrator of the finding at the Life Safety Code survey exit on 03/31/22. NJAC 8:39-31.2 (e) Life Safety Code 101	K 321	Element 3 Facility will conduct audits of all ceilings to ensure additional penetration doesn't exist and any additional penetrations will be sealed with a fire rated assembly that is at least equal too the rating of the ceiling The Maintenance log was updated to include monthly checks of all ceiling penetrations Element 4 The Maintenance Director will conduct walking records monthly and document the areas noted in element 1 above. The Maintenance Director will report all findings to the Administrator and QA committee monthly for one quarter and then randomly or as needed based on the recommendations of the QA committee after the quarter.	
K 355 SS=E	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of facility documentation on 03/30/2022 in the presence of facility management, it was determined that the facility failed to a.) install 8 of 26 portable fire extinguishers within the required	K 355	Element 1 The following ABC fire extinguishers were lowered to under 5□ to 4□11 from the floor to the top of extinguishers listed.	5/5/22

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K 355	Continued From page 6 height, and b.) perform and document on the tag attached to the fire extinguisher a monthly visual examination for 3 of 26 fire extinguishers, as required by NFPA 101, 2012 Edition, Section 19.3.5.12, 9.7.4.1 and National Fire Protection Association (NFPA) 10, 2010 Edition, Sections 6.1, 6.1.3.8.1 and 6.1.3.8.3 and N.J.A.C. 5:70. 1. On 03/30/2022 starting at 9:02 AM with the facility's Regional Administrator (RA) and Director of Maintenance (DOM), a tour of the building was conducted. During the tour, the surveyor observed 8 of 26 portable fire extinguishers were installed too high (5'-2" to 5'-7" high) in the following locations: Basement level, a.) One ABC type extinguisher in the Commercial Laundry was installed 5'- 5" to the center of the pressure indicating needle. b.) One ABC type extinguisher in the Corridor was installed 5'- 7" to the center of the pressure indicating needle. c.) One ABC type extinguisher in the Laundry Chute room was installed 5'- 2" to the center of the pressure indicating needle. d.) One ABC type extinguisher in the Boiler room was installed 5'- 2" to the center of the pressure indicating needle. e.) One ABC type extinguisher in the Main Electrical room was installed 5'- 5 1/2" to the center of the pressure indicating needle. First floor, f.) One ABC type extinguisher next to the ██ Wing	K 355	Basement level, a.) One ABC type extinguisher in the Commercial Laundry was installed 5'- 5" to the center of the pressure indicating needle. The extinguisher was lowered to 4□11 from the floor to the top of extinguisher b.) One ABC type extinguisher in the Corridor was installed 5'- 7" to the center of the pressure indicating needle. The extinguisher was lowered to 4□11 from the floor to the top of extinguisher c.) One ABC type extinguisher in the Laundry Chute room was installed 5'- 2" to the center of the pressure indicating needle. The extinguisher was lower to 4□11 from the floor to the top of extinguisher d.) One ABC type extinguisher in the Boiler room was installed 5'- 2" to the center of the pressure indicating needle. The extinguisher was lowered to 4□11 from the floor to the top of extinguisher e.) One ABC type extinguisher in the Main Electrical room was installed 5'- 5 1/2" to the center of the pressure indicating needle. The extinguisher was lowered to 4□11 from the floor to the top of extinguisher First floor, f.) One ABC type extinguisher next to the A Wing unit dayroom was installed 5'- 5 1/2" to the center of the pressure	

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K 355	Continued From page 7 unit [redacted] was installed 5'- 5 1/2" to the center of the pressure indicating needle. g.) One ABC type extinguisher on [redacted] -Wing unit to the left of Resident room [redacted] was installed 5'- 5 1/2" to the center of the pressure indicating needle. h.) One ABC type extinguisher on [redacted] -Wing unit to the right of Resident room [redacted] was installed 5'- 3" to the center of the pressure indicating needle. The surveyor recorded the measurements from the floor to the extinguishers pressure indicating needle, 2. Along the tour the surveyor observed 26 fire extinguishers were last annually inspected in October 2021, with no evidence of a monthly visual inspection being documented on the tags attached to three (3) fire extinguishers in the following location: While on tour in the Maintenance shop, the surveyor observed 3 fire extinguishers and asked the DOM if they were spare fire extinguishers. The DOM told the surveyor, yes they are. If I need to replace one, I use one of these. The surveyor observed tags attached to the extinguishers reflected the last annual inspection in October 2021, with no evidence of a monthly examination performed and documented on the tags. The findings were verified and confirmed by the RA and DOM during the observations. The surveyor informed the Administrator of the finding at the Life Safety Code survey exit on	K 355	indicating needle. The extinguisher was lowered to 4□11 from the floor to the top of extinguisher g.) One ABC type extinguisher on [redacted] -Wing unit to the left of Resident room #[redacted] was installed 5'- 5 1/2" to the center of the pressure indicating needle. The extinguisher was lowered to 4□11 from the floor to the top of extinguisher h.) One ABC type extinguisher on [redacted] -Wing unit to the right of Resident room [redacted] was installed 5'- 3" to the center of the pressure indicating needle. The extinguisher was lowered to 4□11 from the floor to the top of extinguisher 2. the 3 spare extinguishers are now included in a created checklist with extinguishers locations to ensure all extinguishers are visually inspected monthly, and that the tags are documented that they are signed. Element 2 All residents have the potential to be affected by this practice Element 3 The Maintenance log was updated to include monthly documentation that all extinguishers including the 3 spares are visually inspected and are included in a created checklist with location monthly All new extinguishers will be attached at	

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K 355	Continued From page 8 03/31/22. NFPA 10 NJAC 8:39 -31.1 (c), 31.2 (e).	K 355	the correct height. Element 4 The Maintenance Director will conduct walking rounds monthly and document that all extinguishers have been visually inspected. The Maintenance Director will report all findings to the Administrator and QA committee monthly for one quarter and then randomly or as needed based on the recommendations of the QA committee after the quarter.	
K 374 SS=D	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observations on 03/30/2022, in the presence of facility management, it was determined that the facility failed to maintain smoke barrier doors to resist the transfer of smoke when completely closed for fire protection.	K 374	Element 1 The █ wing Smoke Barrier doors metal door sweeps were lowered to allow 1/8 of an inch gap at the bottom of the █ wing	5/5/22

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K 374	Continued From page 9 This deficient practice was identified for 2 of 5 smoke barrier doors and was evidenced by the following: On 03/30/2022 starting at 9:02 AM with the facility's Regional Administrator (RA) and Director of Maintenance (DOM), a tour of the building was conducted. During the tour, the surveyor observed and tested five (5) sets of double smoke barrier doors in the corridors with the following results: 1) At 10:21 AM, in the [redacted] Wing unit, when manual testing of the facility's smoke barrier doors between resident room [redacted] and resident room [redacted] revealed it was not resistant to the transfer of smoke with an observed gap greater than 3/4 of an inch from the floor to the bottom of the door. At this time, the surveyor used a construction tape measure and recorded a 1-1/2 inch gap along the bottom edge. This would allow the transfer of smoke, fire and poisonous gasses to pass from one smoke compartment to another in the event of a fire. 2) At 11:50 AM, in the [redacted] Wing unit, when manual testing of the facility's smoke barrier doors next to resident room [redacted] and resident room [redacted], revealed it was not resistant to the transfer of smoke with an observed a gap greater than 3/4 of an inch from the floor to the bottom of the door. At this time, the surveyor used a construction tape measure and recorded a 1-1/2 inch gap along the bottom edge. This would allow the transfer of smoke, fire and poisonous gasses to pass from one smoke compartment to another in the event of a fire.	K 374	smoke barrier doors The [redacted] wing smoke barrier door metal door sweeps were lowered to allow 1/8 of an inch gap at the bottom of [redacted] wing smoke barrier doors Element 2 All residents have the potential to be affected by this practice Element 3 The smoke barrier door log was updated to include proper gapping of the smoke barrier doors Element 4 The Maintenance Director will conduct walking rounds weekly and document the condition of the smoke barrier doors. The Maintenance director will report all findings to the administrator and QA committee Monthly for one quarter and them randomly Or as needed based on the recommendations of the QA committee after the quarter	

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K 374	Continued From page 10 The findings were verified and confirmed by the RA and DOM during the observations. The surveyor informed the Administrator of the finding at the Life Safety Code survey exit on 03/31/22. N.J.A.C. 8:39-31.1(c), 31.2(e)	K 374		
K 521 SS=D	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on observations and interview conducted on 03/30/2022, in the presence of facility management, it was determined that the facility failed to ensure that the facility's ventilation systems were a.) being properly maintained for 1 of 10 resident bathroom exhaust systems and b) provided an exhaust system for 1 of 10 Resident bathrooms as per the National Fire Protection Association (NFPA) 90A. This deficient practice was evidenced by the following: During a tour of the building starting at 9:02 AM,	K 521	Element 1 1.█ wing unit resident room █ bathroom exhaust fan was replaced with a new exhaust fan 2. █ wing unit resident room █ bathroom window screws were removed to allow the window to open freely Element 2 All residents have the potential to be affected by this practice	5/5/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315263	A. BUILDING **01** B. WING ______	03/31/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 521	Continued From page 11 in the presence of the facility's Regional Administrator (RA) and Director of Maintenance (DOM), an inspection inside of ten (10) resident bathrooms was performed. The inspection identified that when the resident bathroom exhaust systems were tested (by placing a piece of single ply tissue paper across the grills to confirm ventilation is present), the exhaust did not function properly in 1 of 10 resident bathrooms and 1 of 10 resident bathrooms had no exhaust system in the following locations: 1. At 11:19 AM, on the █-Wing unit inside resident room ███ bathroom, the exhaust system did not function properly when tested. At this time, the surveyor informed the RA and DOM that the exhaust system did not function properly. 2. At 12:01 PM, on the █-Wing unit inside Resident room #██'s bathroom, there was no exhaust system. The surveyor observed a window in the bathroom and made a request to the DOM, does the window open. At this time the DOM attempted to open the window. The window did not open and the DOM stated that the window was screwed closed. The surveyor observed eight (8) Resident bathrooms had no windows with an area that would open. The bathrooms would rely on mechanical ventilation. The RA and DOM confirmed the finding at the time of the observation. The surveyor informed the Administrator of the finding at the Life Safety Code survey exit on 03/31/22.	K 521	Element 3 The maintenance log was updated to include weekly checks of bathroom exhaust fans and Bathroom windows Element 4 The Maintenance Director will conduct walking rounds weekly and document the condition of the bathroom exhaust fans and bathroom windows. The Maintenance director will report all findings to the administrator and QA committee Monthly for one quarter and them randomly Or as needed based on the recommendations of the QA committee after the quarter	

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	315263	A. BUILDING 01 B. WING ______	03/31/2022

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K 521	Continued From page 12 NFPA 90A. NJAC 8:39- 31.2 (e).	K 521		
K 541 SS=E	Rubbish Chutes, Incinerators, and Laundry Chu CFR(s): NFPA 101 Rubbish Chutes, Incinerators, and Laundry Chutes 2012 EXISTING (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1-hour. All new chutes shall comply with 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4. (Existing laundry chutes permitted to discharge into same room are protected by automatic sprinklers in accordance with 19.3.5.9 or 19.3.5.7.) (4) Existing fuel-fed incinerators shall be sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82 This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 03/30/2022, in the presence of facility management, it was determined that the facility failed to maintain the one hour fire-resistive construction for 1 of 1 corridor linen chutes in accordance with Life Safety Code 101: 2012 -19.5.4.	K 541	Element 1 The █ wing Laundry chute door lock and latch were replaced with a new Lock and latch. After installation of the new lock and latch the laundry chute door closes and has positive latch into its frame to	5/5/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315263	A. BUILDING 01 B. WING	03/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 541	Continued From page 13 This deficient practice was evidenced as follows: During a tour of the building starting at 9:02 AM, in the presence of the facility's Regional Administrator (RA) and Director of Maintenance (DOM), at 10:45 AM an inspection in the █-Wing unit was performed. The surveyor observed a laundry chute in the corridor located between resident rooms ███ and ███. At that time, a closure test of the laundry chute door was conducted. When the DOM opened the chute door and allowed the chute door to self-close, the chute door did not close and positive latch into its frame to maintain the 1-hour fire rating. This test was repeated two additional times with the same result. The findings were verified and confirmed by the RA and DOM during the observations. The surveyor informed the Administrator of the finding at the Life Safety Code survey exit on 03/31/22 . Life Safety Code 101:2012 -19.5.4 NJAC 8:39 -31.2(e)	K 541	maintain the 1 hour fire rating Element 2 All residents have the potential to be affected by this practice Element 3 The maintenance log was updated to include weekly checks of the █ wing laundry chute door to ensure proper function. The Staff was in-service on the proper use of the laundry chute, and notify maintenance immediately of any malfunctions. Element 4 The Maintenance Director will conduct walking rounds weekly and document the condition of the laundry chute door and report all findings to the administrator and QA committee Monthly for one quarter and them randomly or as needed based on the recommendations of the QA committee after the quarter	
K 912 SS=D	Electrical Systems - Receptacles CFR(s): NFPA 101 Electrical Systems - Receptacles Power receptacles have at least one, separate, highly dependable grounding pole capable of maintaining low-contact resistance with its mating plug. In pediatric locations, receptacles in patient rooms, bathrooms, play rooms, and activity	K 912		5/5/22

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	315263	A. BUILDING **01** B. WING ____	**03/31/2022**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 912	Continued From page 14 rooms, other than nurseries, are listed tamper-resistant or employ a listed cover. If used in patient care room, ground-fault circuit interrupters (GFCI) are listed. 6.3.2.2.6.2 (F), 6.3.2.2.4.2 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 03/30/2022, in the presence of facility management, it was determined that the facility failed to ensure that 1 of 4 electrical outlets located next to a water source were equipped with proper working Ground-Fault Circuit Interrupter (GFCI) protection. This deficient practice was evidenced as follows: During the building tour starting at 9:02 AM, in the presence of the facility's Regional Administrator (RA) and Director of Maintenance (DOM), a tour of the facility was conducted. During the tour at 12:28 PM, an inspection of the Salon was performed. The surveyor observed one Quad (4) electrical outlet located two (2) feet to the right of the hair washing sink. When the surveyor used a GFCI tester to de-energize the Quad electrical outlet, the Quad electrical outlet did not de-energize, as required by code. The RA and DOM confirmed the finding at the time of the observation. The surveyor informed the Administrator of the finding at the Life Safety Code survey exit on 03/31/22. NJAC 8:39 -31.2 (e) NFPA 99	K 912	Element 1 The Quad (4) electrical outlets located in the salon next to the hair wash sink were replaced with four new (GFCI) ground fault circuit interrupter outlets Element 2 All residents have the potential to be affected by this practice Element 3 The maintenance log was updated to check all GFCI ground -fault circuit interrupter outlets Element 4 The Maintenance Director will conduct walking rounds monthly and document all findings The Maintenance Director will report all findings to the administrator and QA committee Monthly for one quarter and them randomly or as needed based on the recommendations of the QA committee after the quarter	