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 _____	**06/03/2021**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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 that was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 06/01/21 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 2-story building that was built in the 1980's and is composed of Type II construction. The facility is divided into 10 smoke zones. The generator does approximately 30% of the building. The facility utilized 1135 waivers allowing for regulatory flexibilities during the Public Health Emergency for routine inspection, testing and maintenance requirements beginning January 31, 2020. The flexibilities did not extend to the following items: fire pump weekly/monthly testing, fire extinguisher monthly inspections, fire fighter operation monthly testing for elevators, monthly testing of generators, and daily inspection of the means of egress in areas of construction, repair, alterations or additions.	K 000		
K 222 SS=E	Egress Doors CFR(s): NFPA 101	K 222		6/18/21

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

Electronically Signed | 06/11/2021

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K 222	Continued From page 1 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and	K 222		

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K 222	Continued From page 2 ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 06/01/21, in the presence of Maintenance Director and Regional Plant Operations Director, it was determined that the facility failed to maintain 3 of 3 means of egress double exit doors to operate in a manner free of obstructions or impediments, in accordance with NFPA 101, 2012 LSC Edition, Section 19.2.1, 19.2.2, 19.2.2.2.4, 7.2.1, 7.2.1.6.1, 7.2.1.5.10.2, 7.2.1.5.11 and 7.10.1.2.1. This deficient practice was evidenced by the following: 1. On 06/01/21 at 12:58 PM, the surveyor observed the double exit doors in [redacted]-Wing, by resident room [redacted]. When the activation code was entered, the left-side door opened, but the	K 222	Element 1 All manual locks were removed from the double exit doors in [redacted] wing by resident room [redacted], the double exit doors in the [redacted] Wing dining room and the double exit doors in the [redacted] wing [redacted]. All 3 doors were checked by maintenance and now function properly. 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 all emergency exits.Maintenance staff received	

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K 222	Continued From page 3 right-side door leaf remained closed, unless the manual door edge top and bottom latches were unlocked. 2. On 06/01/21 at 01:10 PM, the surveyor observed the double exit doors in the [redacted]-Wing dining room. When the activation code was entered, the left-side door opened, but the right-side door leaf remained closed, unless the manual floor latch were unlocked. 3. On 06/01/21 at 01:18 PM, the surveyor observed the double exit doors in the [redacted]-Wing classroom. When the activation code was entered, the left-side door opened, but the right-side door leaf remained closed, and required the release of a manual flush bolt to open. Means of egress (both doors) shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. At that time, an interview was conducted with the Maintenance Director and the Regional Plant Operations Director and they agreed that the right-side exit door leafs were manually locked on all three doors. The Administrator was notified of the findings at the Life Safety Code exit conference on 06/01/21.	K 222	re-education. Element 4 The Maintenance Director will conduct walking rounds and document the condition of the double exit doors and review the maintenance log. 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 241 SS=D	NJAC 8:39-31.2(e) 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,	K 241		8/27/21

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K 241	Continued From page 4 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: Based on observation and interview on 06/01/21, in the presence of Maintenance Director and Regional Plant Operations Director, it was determined that the facility failed to ensure that 2 acceptable exits, remote from each other, were provided for each floor/story of the building. This deficient practice was evidenced by the following: At 11:00 AM, the surveyor, together with the facility's Maintenance Director and Regional Plant Operations Director, 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 three business staff members occupying the [redacted] floor offices. When interviewed, the Maintenance Director and Regional Plant Operations Director, 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 Maintenance Director and Regional Plant Operations Director further stated that staff would	K 241	Facility had an FSES inspection done and it passed. K241 Element One Facility staff receive education on hire and annually about evacuation procedures from the second floor in the event of the need to evacuate. There is a key-pad lock to the [redacted] floor, and it is only used by administration, department heads, business office and medical records. The [redacted] floor has a fully functional fire system, alarm system and an automatic fire sprinkler system. Element Two 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. Element Three An annual fire drill will be conducted by the vendor that is focused on evacuation from the [redacted]-floor business office. Element Four	

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K 241	Continued From page 5 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. The Maintenance Director and Regional Plant Operations Director, were informed that the facility is required to have a Fire Safety Evaluation System (FSES) and was provided a document "instructions for past waivered citations". NJAC 8:39-31.1(c), 31.2(e)	K 241	The Maintenance Director and Administrator conduct monthly rounds to monitor the [redacted] floor to assure there are no potential hazards. Findings are discussed and corrective actions implemented as appropriate at the quarterly QA committee meeting. Maintenance Director will ensure that an FSES would be conducted annually.	
K 281 SS=D	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 06/01/21, in the presence of the Maintenance Director and Regional Plan Operations Director, it was determined that the facility failed to ensure that exit discharge areas were equipped with two sources of lighting for 1 of 6 exit discharge areas observed. This deficient practice was evidenced by the following: The surveyor observed the [redacted]-wing boiler room exit. The exterior overhang, single-bulb light fixture, did not have a bulb in place.	K 281	Element 1 The [redacted] wing boiler room outside exit single-bulb light fixture was repaired.Maintenance installed a new light bulb and checked for functionality. 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 all outside lighting to ensure proper	6/18/21

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K 281	Continued From page 6 An interview was conducted with the Maintenance Director and Regional Plant Operations Director, who confirmed the single-bulb fixture did not have a bulb in place. The Administrator was notified of the findings at the Life Safety Code Exit Conference on 06/01/21. NJAC 8:39-31.2(e) NFPA 101 (2012 edition)19.2.8 Illumination of means of egress	K 281	function.Maintenance staff received re-education. Element 4 The Maintenance Director will conduct walking rounds and document the function of all exit door lights and review the maintenance log. 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 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 06/01/21,	K 353	Element 1	6/18/21

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K 353	Continued From page 7 in the presence of the Maintenance Director and Regional Plant Operations Director, the facility failed to maintain the sprinkler system, by ensuring the ceiling level was smoke resistant for 9 of 9 sprinkler observations, in accordance with NFPA 101, 2012 LSC Edition, Section 19.3.5.1, Section 4.6.12, Section 9.7, NFPA 13, 2010 Edition, Section 6.2.7.1 and NFPA 25, 2011 Edition, Section 5.1, 5.2.2.1. The deficient practice was evidenced as follows: Throughout a tour of the facility starting at 11:00 AM, observations were made as follows: 1. The surveyor observed a fire sprinkler escutcheon plate not in place in the [redacted] floor closet, outside the bathroom, leaving a 1/2" opening into the ceiling, allowing hot gasses and smoke past the sprinkler into the space above. 2. The surveyor observed a fire sprinkler escutcheon plate not in place in the [redacted]-wing exit corridor ceiling, by resident rooms [redacted] and [redacted], leaving a gap approximately 1/2", allowing hot gasses and smoke past the sprinkler into the space above. 3. The surveyor observed in the laundry room, by the 4 commercial dryers, an approximately 3" opening in the ceiling, allowing hot gasses and smoke past the sprinkler into the space above. 4. The surveyor observed in the boiler room an approximately 6" x 6" piece of ceiling was missing, allowing hot gasses and smoke past the sprinkler into the space above. 5. The surveyor observed in the corridor ceiling,	K 353	The following areas were immediately repaired: 1a. Escutcheon plate was installed on the [redacted] floor closet. 2a. Escutcheon plate was installed by resident rooms [redacted] and [redacted]. 3a. 3 opening in the ceiling by the 4 commercial dryers was corrected with 5/8 sheetrock. 4a. 6x 6 opening in the boiler room ceiling was corrected with 5/8 sheetrock. 5a. ¿ opening in the corridor ceiling by resident room [redacted] was corrected with a new ceiling tile cut to close the ¿ opening in the corridor ceiling. 6a. Escutcheon plate was installed in the Telephone room by resident room [redacted] 7a. 2x2 vertical opening in [redacted]-wing dining room was corrected by replacing the ceiling tile to close the 2x2 opening and was then sealed with fire rated caulk around the pipe. 8a. New ceiling tile was installed by resident room [redacted] 9a The ceiling tile was replaced to close up the ¿ opening at the ceiling by resident room [redacted]. Element 2 All residents have the potential to be affected by these practices. Element 3 The Maintenance logs were updated to check all sprinkler heads, escutcheon plate and ceiling tiles weekly.Maintenance staff received re-education. Element 4	

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K 353	Continued From page 8 by resident room 23, a 1/2" opening by the split ceiling tile, allowing hot gasses and smoke past the sprinkler into the space above. 6. The surveyor observed in the telephone room, by resident room [redacted], an escutcheon plate was not in place, allowing hot gasses and smoke past the sprinkler into the space above. 7. The surveyor observed in the [redacted]-wing dining room by the TV, an approximately 2" x 2" vertical opening around the pipe, allowing hot gasses and smoke past the sprinkler into the space above. 8. The surveyor observed outside resident room 84, a 2' x 2' ceiling tile was missing, allowing hot gasses and smoke past the sprinkler into the space above. 9. The surveyor observed outside resident room [redacted], a sprinkler head had approximately an 1/2" opening at the ceiling, allowing hot gasses and smoke past the sprinkler into the space above. The findings were verified by the Maintenance Director and Regional Plant Operations Director at the time of the observations. The administrator was notified of the findings at the Life Safety Code exit conference on 06/01/21. NJAC 8:39-31.2(e)	K 353	The Maintenance Director will conduct walking rounds and document the areas noted in element one above and review the maintenance log. 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. see attached files	
K 374 SS=D	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING	K 374		6/18/21

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K 374	Continued From page 9 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 observation and interview on 06/01/21, in the presence of the Maintenance Director and Regional Plant Operations Director, it was determined that the facility failed to maintain 1 of 9 smoke barrier doors to automatically close with the activation of the fire alarm system, in order to provide at least 20 minutes of fire protection. This deficient practice was evidenced by the following: At 12:50 PM, the surveyor observed on the [redacted]-Wing, the single smoke barrier door, near resident rooms [redacted] and [redacted], did not fully close when released from the magnetic hold-open device. When released, the single door remained open approximately 2' due to the bottom door sweep rubbing onto the floor, preventing it from being smoke resistive. The Maintenance Director attempted to release the door 3 more times, and with all three activations from the magnetic hold-open device, the door remained open approximately 2'. An interview was conducted with the Maintenance	K 374	Element 1 The single smoke barrier door near resident rooms [redacted] and [redacted], door sweep was corrected to allow the smoke barrier door to fully close. Element 2 All residents have the potential to be affected by this practice Element 3 The Maintenance log was updated to include daily checks ofall smoke barrier doors.Maintenance staff received re-education. Element 4 The Maintenance Director will conduct walking rounds and document the condition of the door sweeps and review the maintenance log. 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	

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K 374	Continued From page 10 Director and the Regional Plant Operations Director, and they both agreed that the door remained open approximately 2' due to the bottom door sweep rubbing onto the floor. The Administrator was notified of the finding at the Life Safety Code exit conference on 06/01/21. NJAC 8:39-31.1(c), 31.2(e)	K 374	of the QA committee after the quarter.	
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by:	K 920		6/18/21

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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 920	Continued From page 11 Based on observation and interview on 06/01/21, in the presence of the Maintenance Director and Regional Plant Operations Director, it was determined that the facility failed to maintain wiring, in the main egress corridor, in accordance with NFPA 70 (National Electrical Code). This deficient practice was evidenced by the following: At 11:15 AM, the surveyor observed in the main egress corridor, by the receptionist's desk, an orange extension cord coming from the closed Administrator's office door and plugged into an employees' time clock. The orange extension cord was running under the hinge-side of the door, showed signs of stress at the bending points of the wire, and could be pinched as it was laying on the floor. The extension cord was plugged into the duplex wall outlet in the Administrator's office. An interview was conducted with the Maintenance Director and Regional Plant Operations Director. They stated that the orange extension cord was due to the new placement of the time clock due to Covid-19. The Administrator was notified of the finding at the Life Safety Code Exit conference on 06/01/21. NJAC 8:39-31.2(e) NJAC 8:39-31.7(g) NFPA 70, 99	K 920	Element 1 The orange extension cord coming from Administrator office was removed and the Time clock was Relocated back to original location on B-wing corridor. Element 2 All residents have the potential to be affected by this practice. Element 3 The Maintenance Director will conduct daily checks for the use of any extension cords.Maintenance staff received re-education. Element 4 The Maintenance Director will conduct walking rounds and monitor to ensure no extension cords are in use and review the maintenance log. 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.	