STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315263	A. BUILDING _____ B. WING _____	C 03/23/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS C #: NJ00162163 Census: 159 Sample: 5 THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Complaint # : NJ162163 Based on interviews and record review, as well as review of pertinent facility documents on 3/13/23 and 3/23/23, it was determined that the facility failed to follow physician's order and follow the facility policies on "Medication Administration" according to standards of practice for 1 of 3 residents (Resident #2), reviewed for medication administration. This deficient practice is evidenced by the following: 1. According to the Admission Record, Resident #2 was admitted to the facility on [redacted] with diagnoses which included but were not limited to:	F 658	Facility ID 315263 1. Corrective Action: The physician was notified of Resident #2 undocumented medications in medication administration record. Licensed nursing staff who did not document in the medication administration record were educated immediately on the rights of medication administration. 2. All residents have the potential to be affected by this deficient practice. An audit was completed of all residents to ensure all residents medication administration records were documented appropriately discrepancies were addressed if necessary.	4/24/23

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

Electronically Signed | 04/25/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315263	A. BUILDING _____ B. WING _____	C 03/23/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 1 [redacted]. The Minimum Data Set (MDS), an assessment tool dated [redacted], revealed that Resident #2 had a Brief Interview for Mental Status (BIMS) score of [redacted], indicating Resident #2's [redacted] was [redacted] and the resident required supervision for Activities of Daily Living (ADLs). The care plan (CP) dated [redacted] 1 and revised on [redacted], indicated Resident #2 had [redacted] Interventions included but were not limited to: administer medications as ordered. The "Order Summary Report (OSR)" dated [redacted] indicated the following Physician's orders: On [redacted] tablet [redacted] milligram (mg) give [redacted] tablet by mouth [redacted] times a day for [redacted]. On [redacted], [redacted] tablet [redacted] mg give [redacted] tablet by mouth [redacted] times a day for [redacted]. On [redacted] tablet [redacted] mg give [redacted] tablets by mouth at bedtime for [redacted] On [redacted] tablet [redacted] mg give [redacted] tablet by mouth every [redacted] hours for [redacted]. On [redacted] Behavior and Intervention Monitoring see key every shift Behavior(s) Exhibited: 0. None, 1. Agitated 2. Anxious 3. Biting 4. Pacing 5. Crying 6. Screaming/Yelling 7. Hallucinations/Paranoia/Delusions 8. Insomnia 9. Striking out/hitting 10. Withdrawn.	F 658	3. Systemic Changes: The Director of Nursing or designee educated licensed staff on nursing documentation and ensuring appropriate documentation is documented after administering medications, treatments and or interventions are completed. 4. Quality Assurance : The Director of Nursing or designee will audit resident mars/tars every shift daily for 4 weeks then monthly times two. Needed corrections will be addressed as they are discovered. Results will be reported to QAPI committee for further review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315263	A. BUILDING _____ B. WING _____	C 03/23/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 2	F 658		

On [redacted], Behavior and Intervention Monitoring see key every shift intervention(s): 0. None 1. Redirect 2. Close Monitoring 3. Activity 4. Toileting 5. Fluids/Food 6. Adjust Environment 7. Change position 8. Massage 9. Medication.
On 10/28/22, Behavior and Intervention Monitoring see key every shift, record potential side effects: 0. None 1. Stiff Neck 2. Tremors 3. Confusion 4. Tardive Dyskinesia 5. Hypotension/ Dizziness 6. Dehydration 7. Insomnia 8. Anxiety/ Agitation 9. Sedation 10. Appetite Changes on 10/28/22.

The "MEDICATION ADMINISTRATION RECORD (MAR)" for the month of [redacted] and [redacted] confirmed the aforementioned physician orders however on the following dates, times, and/or shifts the MAR was not signed/initialed by a nurse to indicate the medications were given and to indicate that behaviors were monitored.

[redacted] tablet [redacted] mg: 5:00 pm dose on 2/9/23, 2/12/23, 2/16/23, and 2/26/23.

[redacted] tablet [redacted] mg; 5:00 pm dose on 1/5/23, 2/9/23, 2/12/23, 2/16/23, and 2/26/23.

[redacted] tablet [redacted] mg; 9:00 pm dose on 1/5/23, 1/10/23, 1/29/23, 2/12/23, 2/14/23, 2/16/23, 2/21/23, 2/25/23, 2/26/23, and 2/27/23.

[redacted] tablet [redacted] mg 9:00 pm dose on 1/5/23, 1/10/23,1/29/23, 2/12/23, 2/14/23, 2/16/23, 2/21/23, 2/25/23, 2/26/23, and 2/27/23.

Behavior and Intervention Monitoring; 3:00 pm to 11:00 pm shift on 1/5/23, 2/12/23, 2/16/23, and 2/26/23 and, 11:00 pm to 7:00 am shift on 1/1/23, 1/19/23, 2/2/23, 2/9/23, 2/17/23, 2/18/23, 2/20/23,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315263	A. BUILDING _____ B. WING _____	C 03/23/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 3	F 658		

2/21/23, 2/25/23, and 2/26/23.

Behavior and Intervention Monitoring see key every shift intervention(s) during the evening shift, 3:00 pm to 11:00 pm on 1/5/23, 2/12/23, 2/16/23, and 2/26/23 and during the night shift, 11:00 pm to 7:00 am, on 1/1/23, 1/19/23, 2/2/23, 2/9/23, 2/17/23, 2/18/23, 2/20/23, 2/21/23, 2/25/23, and 2/26/23.

Behavior and Intervention Monitoring see key every shift, record potential side effects during the evening shift, 3:00 pm to 11:00 pm on 1/5/23, 2/12/23, 2/16/23, and 2/26/23 and during the night shift, 11:00 pm to 7:00 am, on 1/1/23, 1/19/23, 2/2/23, 2/9/23, 2/17/23, 2/18/23, 2/20/23, 2/21/23, 2/25/23, and 2/26/23.

Review of Resident #2's progress notes (PN) did not indicate that the aforementioned medications were administered to Resident #2 or that a Physician was notified that the medication was not administered.

The surveyor conducted an interview with the Director of Nursing (DON) on 3/13/23 and 2:51 pm. The DON stated that the facility's protocol for administering medication was for the nurse to sign the MAR after administering medication to each resident before moving on to the next resident. The DON stated the staff are expected to call a resident's physician when the medications were not administered and document the notification in the resident's MR.

The surveyor conducted an interview with Licensed Practical Nurses (LPN #1 and LPN #2) on 3/23/23 from 10:33 am to 10:49 am. The LPNs stated that nurses are expected to document on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315263	A. BUILDING _____ B. WING _____	C 03/23/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 4 the MAR when medications were administered. They further stated that if there is no documentation on the MAR or in the MR it meant that the medications were not administered. A review of facility policy titled "Medication Administration: General", dated 3/2022, indicated "A licensed nurse ...will administer medications to patients. Accepted standards of practice will be followed ...PURPOSE To provide a safe, effective medication administration process ...11. Document: 11.1 Administration of medication on Medication Administration Record (MAR) ..." A review of facility policy titled "Nursing Documentation", dated 3/1/22, indicated " ...PRACTICE STANDARDS 1. Nurses will not: 1.1 Document services that were not performed ..." NJAC 8:39-27.1(a)	F 658		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315263	A. Building B. Wing	4/26/2023

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0658 Reg. # 483.21(b)(3)(i) LSC	Correction Completed 04/24/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 3/23/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			