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 09/14/2020

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 COMPLANT # NJ CENSUS : 154 SAMPLE SIZE: 4	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced	F 609		10/16/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 10/01/2020

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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PALACE REHABILITATION AND CARE CENTER, THE	**315 WEST MILL ROAD MAPLE SHADE, NJ 08052**

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F 609	Continued From page 1 by: COMPLAINT # NJ 139416 Based on interviews, review of the Medical Record (MR), and other pertinent facility documentation on 9/14/2020, it was determined that the facility failed to report an allegation of physical abuse to the New Jersey Department of Health (NJDOH), as well as follow their own facility policy titled, "Prohibition of Resident Abuse and Neglect," for 1 of 4 sampled residents (Resident #3). This deficient practice is evidenced by the following: 1. According to the "Admission Record," Resident #3 was admitted to the facility on [redacted]. According to the Care Plan (CP) Resident #3's diagnoses included but were not limited to: [redacted] According to the Minimum Data Set (MDS), an assessment tool dated [redacted], Resident #3 had a Brief Interview for Mental Status (BIMS) score of [redacted], indicating that Resident #3 had [redacted]. The MDS documentation indicated that Resident #3 needed [redacted] Review of Resident#3's CP undated, revealed under "Concerns:" I have [redacted], I have [redacted], I am at risk for [redacted]. Under "How you can help me" included : You can help me by [redacted]	F 609	The facility respectfully disagrees with the findings. Not with standing the following POC is being submitted in compliance with federal and state regulations. F 609 Element One Resident #3 was [redacted] from the facility on [redacted] to [redacted]. Resident #3 was admitted to [redacted] in [redacted]. Resident #3 did not return to the facility [redacted] The facility received a call from the hospital on the evening of [redacted] indicating Resident #3 alleged she was [redacted] a staff member. Resident #3 did not report abuse to the facility staff and never returned to [redacted] and could not be interviewed. Immediately after being notified on [redacted] the facility initiated an investigation and did not substantiate the allegation Neither the Resident or any legal representative contacted the facility at any time to report an allegation of abuse. The allegation was reported to the NJDOH on [redacted] The facility staff were re-educated to ensure reporting requirements are immediately reported to authorities as required by regulations.	

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	315263	A. BUILDING ______ B. WING ______	C 09/14/2020

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

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F 609	Continued From page 2	F 609		

Review of a Weekly Assessment sheet dated revealed that Resident #3 "noted with from and also noted from same site."

During an interview on 9/14/2020 at 10:57 a.m., the Director of Nursing (DON) stated when asked how do you handle allegations of staff to resident abuse, responded "lately a patient accused in the hospital (while in the hospital) a CNA (Certified Nursing Assistant) of

During an interview on 9/14/2020 at 1:36 p.m., the DON stated that the allegation of staff to resident abuse was not reported to the New Jersey Department of Health (NJDOH) because "I really wasn't sure, now I know. I thought only if the allegation was substantiated it needed to be reported."

During an interview on 9/14/2020 at 11:05 a.m., the Administrator stated that she was made aware of the abuse allegation by the DON on , and the allegation was not reported because "we were going to report it this morning, then you came in."

Review of a facility policy titled, "Prohibition of Resident Abuse and Neglect," undated, under "Reporting" revealed:

Element Two

All Residents have the potential to be affected.

Element Three

The Social Worker interviewed residents on the unit where Resident #3 resided,and no one witnessed any abuse nor did any residents have any complaints with care.Abuse was not substantiated.

Staff received re-education about the facility policy to notify Administration immediately whenever anyone alleges abuse in person or by phone from an outside agency. The facility protocol was revised to include information provided by an outside agency and staff received re-education.

Element Four

The Administrator/designee will audit all incident reports and concern forms monthly for three months then quarterly thereafter to determine if authorities were notified when required. Findings of these audits will be reported by the Administrator to the Quality Assurance committee at quarterly meetings for action as appropriate.

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PALACE REHABILITATION AND CARE CENTER, THE	**315 WEST MILL ROAD** **MAPLE SHADE, NJ 08052**

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F 609	Continued From page 3 Under 3. Abuse Allegations (Abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property) will be "REPORTED IMMEDIATELY" to the appropriate authorities by the Administrator and/or Director of Nursing including but not limited to, local law enforcement agencies, NJDOH, and NJ Ombudsman in compliance with regulatory requirements. Under 4. Reports must be submitted in writing, which may include incident report, employee statement, grievance/concern form, or other written documentation. NJAC 8:39-9.4 (f)	F 609		

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	10/19/2020

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 F0609 Reg. # 483.12(c)(1)(4) LSC	Correction Completed 10/16/2020	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
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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	
9/14/2020	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO