STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	sipfep	A. BUILDING: _____ B. WING _____	C 04/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ECHELON LAKE	207 LAUREL ROAD VOORHEES, NJ 08043

(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) COMPLETE DATE
H 000	Initials Comments This was a complaint survey conducted on 4/27/23. The facility is not in compliance with N.J.A.C. Title 8 Chapter 43E- General Licensure Procedure and Standards Applicable to All Licensed Facilities.	H 000		
H5790	8:43E-13.4(d) UNIVERSAL TRANSFER FORM:MANDATORY USE OF FORM A licensed healthcare facility or program shall retain a completed copy of the Universal Transfer Form sent with a patient when a patient is transferred as part of the patient's medical record. This REQUIREMENT is not met as evidenced by: Complaint #: NJ00161128 Based on interview and record review, it was determined that the facility failed to retain a completed Universal Transfer Form (UTF) for 1 of 5 residents transferred to the hospital for evaluation, Residents #4. The deficient practice was evidenced by the following: On 4/27/23 at 11:45 a.m., the surveyor reviewed Resident #4's medical record who no longer reside at the facility. The resident's move-in date	H5790		

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

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H5790	Continued From page 1 was in NJ EX Order. 264b1 with diagnoses that included NJ EX Order. 264b1 According to the medical record, Resident #4 was transferred to the hospital on NJ EX Order. 264 for wound debridement and did not return to the facility. Further review of resident's medical record revealed no documented evidence that a copy of the UTF was retained in the medical record when the resident was transferred out to the hospital. At 1:05 p.m., the surveyor interviewed the Health and Wellness Director (HWD) who stated that she could not locate the copy of the UTF for the resident. The HWD was not able to provide the copy of Resident #4's UTF during the survey on 4/27/23.	H5790		
A 000	Initial Comments Initial Comments: TYPE OF SURVEY: Complaint COMPLAINT #: NJ00161128 CENSUS: 124 SAMPLE SIZE: 5 The facility is not in substantial compliance with all of the standards in the New Jersey Administrative Code 8:36, Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes and Assisted Living Programs. The facility must submit a plan of correction, including a completion date for each deficiency and ensure that the plan is implemented. Failure to correct	A 000		

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A 000	Continued From page 2 deficiencies may result in enforcement action in accordance with provisions of New Jersey Administrative Code Title 8, Chapter 43E, Enforcement of Licensure Regulations.	A 000		
A 310	8:36-3.4(a)(1) Administration (a) The administrator or designee shall be responsible for, but not limited to, the following: 1. Ensuring the development, implementation, and enforcement of all policies and procedures, including resident rights; This REQUIREMENT is not met as evidenced by: Complaint #: NJ00161128 Based on interview and record review, it was determined the facility's administrator failed to implement and enforce the facility's policy and procedure titled, "Order Medications-39." The deficient practice is evidence by the following: On 4/27/23 at 10:30 a.m., during an interview with Resident #2 in his/her apartment, the resident in	A 310		

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A 310	Continued From page 3	A 310		

a wheelchair, stated that he/she was in [redacted] and had not received his/her [redacted] NJ EX Order. 264b1 is a medication used for [redacted] NJ EX Order. 264b1) [redacted] t days" and that it had happened before "but not for this long."

At 10:35 a.m., the surveyor interviewed a Certified Medication Assistant (CMA), who indicated that her shift began at 6:00 a.m. and that it was the responsibility of the night shift CMA to have administered the 12:00 a.m. and the 6:00 a.m. NJ EX Order. 264b1 milligram (mg) tablets to Resident #2 on [redacted]. The surveyor then asked the CMA, if the Registered Nurse (RN) was made aware that Resident #2 did not receive his/her [redacted] NJ EX Order. 264b1 doses at 12:00 a.m. and 6:00 a.m. The CMA confirmed and stated that she did not inform the RN.

At 10:40 a.m., the surveyor interviewed the Health and Wellness Director (HWD), who stated that she was not aware that Resident #2 had not received his/her [redacted] medication as aforementioned above.

At 10:50 a.m., the surveyor reviewed Resident #2's medical record (MR) which revealed that the resident was admitted to the facility in [redacted] of [redacted] with diagnoses which included a [redacted] NJ EX Order. 264b1. The MR further revealed a physician's order [redacted] NJ EX Order. 264b1 for [redacted] NJ EX Order. 264b1 [redacted] mg tablet by mouth four times a day for [redacted] NJ EX Order. 264b1

At 10:55 a.m., the HWD stated she contacted the physician and made them aware of the absence of medication for Resident #2, new orders were received, and was awaiting pharmacy delivery of the medication.

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A 310	Continued From page 4 Surveyor's review of the "General Notes from eMAR" provided by the HWD on [NJ EX Order: 264b1], revealed that from [NJ EX Order: 264b1], when Resident #2's [NJ EX Order: 264b1] medication was not available for administration, a Licensed Practical Nurse (LPN) and CMAs documented that the medication was either "not available" or that they were "waiting for the pharmacy delivery of the medication." There was, however, no documentation to indicate that the physician was notified that Resident #2's [NJ EX Order: 264b1] was not available and that the resident was not receiving his/her [NJ EX Order: 264b1] medication. At 4:00 p.m., the surveyor interviewed the HWD who stated the CMA should have notified the RN who then would have called the physician. The surveyor interviewed the Executive Director (ED) who stated that she was also not aware that Resident #2 had not received his/her [NJ EX Order: 264b1] medication as aforementioned above. Surveyor's review of facility provided "Order Medications - 39" policy, revised in March 2019, revealed this statement, "Notify the resident, family or contact the physician for a new order/prescription when a routine medication refill orders are depleted." This policy was not implemented by staff when Resident #2 ran out of pain medication and did not receive the oxycodone from 4/21/23 to 4/27/23.	A 310		
A 369	8:36-4.1(a)(8) Resident Rights (a) Each assisted living provider will post and distribute a statement of resident rights for all residents of assisted living residences, comprehensive personal care homes, and assisted living programs. Each resident is entitled	A 369		

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A 369	Continued From page 5 to the following rights: 8. The right to receive pain management as needed, in accordance with N.J.A.C. 8:43E-6; This REQUIREMENT is not met as evidenced by: Complaint #: NJ00161128 Based on interview and record review, it was determined that the facility failed to provide the right to receive the [redacted] medication prescribed by a physician for 1 of 5 residents reviewed, Resident #2. This deficient practice was evidenced by the following: On 4/27/23 at 10:30 a.m., the surveyor interviewed Resident #2 in his/her apartment who was in a wheelchair. Resident #2 stated that he/she was in [redacted] and had not received his/her NJ EX Order. 264b1 a [redacted] medication used to treat and manage [redacted], for [redacted] days." The resident stated that it had happened before, but that it was not for this long. During the interview, when surveyor asked for the NJ EX Order. 264b1, utilizing a [redacted] numeric [redacted] rating scale (a tool used in healthcare to measure a person's [redacted]), Resident #2 indicated that his/her [redacted] was at [redacted] on [redacted] At 10:40 a.m., the surveyor interviewed the Health and Wellness Director, who stated that she was not aware that Resident #2 had not received his/her [redacted] medication as mentioned above.	A 369		

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A 369	Continued From page 6 At 10:50 a.m., the surveyor reviewed Resident #2's medical record (MR) which revealed that the resident was admitted to the facility in [redacted] of [redacted] with diagnoses which included a [redacted] and [redacted]. The MR further revealed a physician's order [redacted], which states, "[redacted] milligram (mg) tablet by mouth [redacted] times a day for [redacted]." The surveyor reviewed Resident #2's electronic Medication Administration Record (eMAR) which included the current medication order, [redacted] mg tablet by mouth [redacted] times a day for [redacted] Further review of the eMAR revealed that the physician ordered [redacted] medication, [redacted] mg, was not administered to the resident from [redacted] through [redacted]. The resident did not receive [redacted] doses of [redacted] relieve his/her [redacted] Refer to 8:36-11.5(f) Complaint #: NJ00161128 Based on interview and record review, it was determined that the facility failed to provide the right to receive the [redacted] medication prescribed by a physician for 1 of 5 residents reviewed, Resident #2. This deficient practice was evidenced by the following: On 4/27/23 at 10:30 a.m., the surveyor interviewed Resident #2 in his/her apartment who was in a wheelchair. Resident #2 stated that he/she was in [redacted] and had not received his/her [redacted]), a [redacted] medication used to treat and manage [redacted], for [redacted] days." The resident stated that it had	A 369		

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A 369	Continued From page 7 happened before, but that "it was not for this long." During the interview, when surveyor asked for the [redacted] intensity, utilizing a [redacted] numeric [redacted] rating scale (a tool used in healthcare to measure a person's [redacted] Resident #2 indicated that his/her [redacted] level was at [redacted] on [redacted]. At 10:40 a.m., the surveyor interviewed the Health and Wellness Director, who stated that she was not aware that Resident #2 had not received his/her [redacted] medication as mentioned above. At 10:50 a.m., the surveyor reviewed Resident #2's medical record (MR) which revealed that the resident was admitted to the facility in [redacted] of [redacted] with diagnoses which included a [redacted] and [redacted]. The MR further revealed a physician's order dated [redacted], which states, "[redacted] milligram (mg) tablet by mouth [redacted] times a day for [redacted] The surveyor reviewed Resident #2's electronic Medication Administration Record (eMAR) which included the current medication order, "[redacted] mg tablet by mouth [redacted] times a day for [redacted] Further review of the eMAR revealed that the physician ordered pain medication, [redacted] mg, was not administered to the resident from [redacted] through [redacted] The resident did not receive [redacted] doses of [redacted] as per physician's order, to relieve his/her [redacted] Refer to 8:36-11.5(f)	A 369		
A 779	8:36-7.5(c) Resident Assessments and Care Plans	A 779		

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A 779	Continued From page 8	A 779		

(c) The registered professional nurse shall be called at the onset of illness, injury or change in condition of any resident to arrange for assessment of the resident's nursing care needs or medical needs and for needed nursing care intervention or medical care.

This REQUIREMENT is not met as evidenced by:
Complaint: NJ00161128

Based on interview and record review, it was determined that the facility failed to provide documented evidence that the Registered Professional Nurse (RN) was notified of a change in condition for 1 of 5 residents reviewed, Resident #2. This deficient practice was evidenced by the following:

On 4/27/23 at 10:30 a.m., the surveyor interviewed Resident #2 in his/her apartment who was in a wheelchair. The resident stated that he/she was in [redacted] and had not received his/her [redacted] is a medication used for [redacted] management) for [redacted] days" and that it has happened before, "but not for this long." Upon further interview, when surveyor asked for the [redacted] intensity utilizing a [redacted] numeric [redacted] rating scale (a tool used in healthcare to measure a [redacted], [redacted] as the worst/great intensity), Resident #2 indicated that his/her [redacted] level was at [redacted] on [redacted].

At 10:35 a.m., the surveyor interviewed a Certified Medication Assistant (CMA), who

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A 779	Continued From page 9	A 779		

indicated that her shift began at 6:00 a.m. and that it was the responsibility of the night shift CMA to have administered the 12:00 a.m., and 6:00 a.m. doses of NJ EX Order. 264b1 milligram (mg) tablets to Resident #2 on NJ EX Order. 264b. The surveyor then asked the CMA if the RN was made aware that Resident #2 did not receive his/her NJ EX Ord medication at 12:00 a.m., and 6:00 a.m. The CMA confirmed that she did not inform the RN.

At 10:50 a.m., the surveyor reviewed Resident #2's medical record (MR) which revealed that the resident was admitted to the facility in NJ EX Order. 2 of NJ EX Ord with diagnoses which included a left heel NJ EX Order. and NJ EX Order. 264b1. Further surveyor's review of the MR revealed a physician's order dated NJ EX Order. 26, which read, "NJ EX Order. 264b1 milligram (mg) tablet by mouth NJ EX Or times a day for NJ EX Order. 264b1.

At 10:40 a.m., the surveyor interviewed the Health and Wellness Director (HWD), who stated that she was not aware that Resident #2 had not received his/her NJ EX Or medication as aforementioned above. The HWD was unaware that Resident #2 continued to have NJ EX Or on NJ EX Or NJ EX Or , NJ EX Order. 264b1b and with NJ EX Or intensity of NJ Ex (#10 as worst).

At 4:00 p.m., the surveyor interviewed the HWD who stated that the CMA should have notified the RN who then would have called the physician for another order. The surveyor then interviewed the Executive Director (ED) who also stated that she not aware that Resident #2 had not received his/her NJ EX Ord medication as aforementioned above.

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A 781	Continued From page 10	A 781		
A 781	8:36-7.5(d) Resident Assessments and Care Plans (d) The resident's physician or the physician's designee, that is, another physician or an advanced practice nurse or physician assistant, shall be notified by the licensed professional nurse of any significant changes in the resident's physical or cognitive/mental condition and any intervention by the physician shall be recorded. This REQUIREMENT is not met as evidenced by: Complaint: NJ00161128 Based on interview and record review, it was determined that the facility failed to provide documented evidence that the physician was notified that a resident's [NJ EX Ord] medication was not available and administered for 1 of 5 residents reviewed, who continued to experience [NJ EX Ord], Resident #2. This deficient practice was evidenced by the following: On 4/27/23 at 10:30 a.m., the surveyor interviewed Resident #2 in his/her apartment in a wheelchair who stated that he/she was in pain and had not received his/her [NJ EX Order, 2645D1] is a medication used for [NJ EX Ord] management) for [NJ EX Order] days" and that it has happened before, "but not for this long." Upon further interview, when surveyor asked for the [NJ EX Ord] intensity utilizing a 0-10 numeric [NJ EX Order, 2645D] scale (a tool used in healthcare to measure a person's [NJ EX Ord] #10 as the worst/greatest intensity), Resident #2 indicated that his/her [NJ EX Ord] level was at [NJ EX] on both	A 781		

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A 781	Continued From page 11	A 781		

legs.

At 10:35 a.m., the surveyor interviewed a Certified Medication Assistant (CMA), who indicated that her shift began at 6:00 a.m. and that it was the responsibility of the night shift CMA to have administered the 12:00 a.m., and 6:00 a.m. NJ EX Order. 264b1 milligram (mg) tablets to Resident #2 on NJ EX Order. 26[illegible]. The surveyor then inquired from the CMA if the Registered Nurse (RN) was made aware that Resident #2 was not administered his/her NJ EX Orde[illegible] medication at 12:00 a.m., and 6:00 a.m. The CMA confirmed that she did not inform the RN.

At 10:40 a.m., the surveyor interviewed the Health and Wellness Director (HWD), who stated that she was not aware that Resident #2 had not received his/her NJ EX Orde[illegible] medication as aforementioned above.

At 10:55 a.m. on 4/27/2023, the HWD stated she contacted the physician and made the physician aware that Resident #2's NJ EX Orde[illegible] medication had not been available for administration. The HWD stated that new orders were received and that they were waiting for the delivery of the medication from the pharmacy.

Surveyor's review of facility policy for "Order Medications - 39" revised on March 2019, required the following: "Notify the resident, family or contact the physician for a new order/prescription when a routine medication refill orders are depleted."

The facility failed to notify the physician when Resident #2's NJ EX Orde[illegible] medication, NJ EX Order. 264b1 was not availble for administration. Resident #2 continued to experience NJ EX Orde[illegible]

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A1073	8:36-15.6(b) Resident Records (b) All assessments and treatments by health care and service providers shall be entered according to the standards of professional practice. Documentation and/or notes from all health care and service providers shall be entered according to the standards of professional practice. This REQUIREMENT is not met as evidenced by: Complaint #: NJ 00161128 Based on interview and record review, it was determined that the facility failed to provide documented evidence that the physician was notified of the absence of medication for 1 of 5 residents reviewed, Resident #2. This deficient practice was evidenced by the following: On 4/27/23 at 10:50 a.m., the surveyor reviewed Resident #2's medical records (MR) which revealed that the resident was admitted to the facility in NJ EX Order: 26461 with diagnoses which included a NJ EX Order: 26461 and NJ EX Order: 26461 The surveyor review of the electronic Medication Administration Record (eMAR) revealed that Resident #2 was not administered NJ EX Order: 26461 NJ EX Order: 26 mg tablet as prescribed by the physician during the following dates and dose times: - 12:00 a.m. dose on 4/22, 4/23, 4/24, 4/25, 4/26 - 6:00 a.m. dose on 4/22, 4/23, 4/24, 4/25, 4/26 - 12:00 p.m. dose 4/21, 4/22, 4/23, 4/24, 4/25, 4/26 at 12:00 p.m. - 6:00 p.m. dose on 4/21, 4/22, 4/23, 4/24, 4/25,	A1073		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE ECHELON LAKE	207 LAUREL ROAD VOORHEES, NJ 08043

(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) COMPLETE DATE
A1073	Continued From page 13 for a total of 21 doses. At 4:00 p.m., the surveyor interviewed the Health and Wellness Director (HWD) who explained that when a resident runs out of medication, the Certified Medication Aide (CMA) would notify a License Practical Nurse (LPN) or Registered (RN) who then would contact the physician. The surveyor reviewed Resident #2's electronic Progress Notes (PN) from NJ EX Order. 264b1 written by CMAs, which documented that NJ EX Order. 264b1 mg tablets were not available and that they were waiting for pharmacy delivery. Further review of the electonic PN, however, revealed there was no documented evidence that the physician was notified that the [redacted] medication, NJ EX Order. 264b1, was not available and that Resident #2 was not receiving this medication to relieve his/her [redacted]. Resident #2 continued to experience [redacted]	A1073		

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DEFICIENCY TAG# H5790

1. **HOW THE CORRRECTIVE ACTION WILL BE ACCOMPLISHED TO THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE?** Resident was discharged on 1/31/2023 to the hospital and was transferred to a skilled nursing facility. This was a closed file audit. All certified medication aides, and nurses were in-serviced on Universal Transfer Form policy and procedure, and record keeping.

2. **HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFIEICIENT PARACTICE?** Resident charts audited on filed Universal Transfer Form copies. No issues found.

3. **WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WOULD NOT RECUR?** All certified medication technicians and licensed practical nurses were in-serviced on Universal Transfer Policy.

4. **HOW THE FACILITY MONITOR IT'S CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR?** Executive director, Health and Wellness Director (HWD) or its designee to monitor Universal Transfer Form in-service compliance 1x month and as needed thereafter.

COMPLETION DATE: 05/15/2023

DEFICIENCY TAG#: A 310

1. **HOW THE CORRRECTIVE ACTION WILL BE ACCOMPLISHED TO THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE?** Resident #2: Pharmacy delivery NJ EX Order. 264b1 received 4/27/2023. Administered as per doctor's order. Resident was discharged to Skilled Nursing Facility to be with NJ EX Order. 264b1 on NJ EX Order. 264b1. Resident #2: Was seen by primary physician right after the incident. No new interventions and to continue current medications and treatment plan as per primary physician.

2. **HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFIEICIENT PARACTICE?** Reviewed Point Click Care/ e-mar, residents who have active NJ EX Order. 264b1 order were reviewed. No discrepancies found.

3. **WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WOULD NOT RECUR?** All Nurses and certified medication aids were in-serviced on Brookdale policy and procedure on "How to Order Medications-39". Nurses and certified medication aides were in-serviced on Brookdale policy and procedure and NJ Medication Aide program guidance on "Processes and systems on: ordering medications, delivery of meds, receiving and verification of meds delivered, storage of medications, medication delegation process to nurses and CMAs, and e-mar documentation" with focus on Controlled Substance/ Narcotics. Mandatory in-services to all certified medication aides and nurses on timely RN notification of the following; NJ EX Order., medication not available, and primary care physician notification on missed medications was completed.

4. **HOW THE FACILITY MONITOR IT'S CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR?** Executive director, HWD or its designee to verify and monitor in-services compliance every week for 1 month, and as needed thereafter.

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COMPLETION DATE: 5/15/23

DEFICIENCY TAG#: A 369

1. **HOW THE CORRRECTIVE ACTION WILL BE ACCOMPLISHED TO THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE?** Resident #2: Pharmacy delivery of oxycodone received 4/27/2023. Administered as per doctor's order. Resident was discharged to Skilled Nursing Facility to be with [redacted] on [redacted] Resident #2: Was seen by primary physician right after the incident. No new interventions and to continue current medications and treatment plan as per doctor's order.

2. **HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE?** Point Click Care/ e-MAR audit indicated that no other residents have been affected. Medical charts audit completed. Copies of Resident Rights in place.

3. **WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WOULD NOT RECUR?** All Nurses and certified medication aides in-serviced on "Bill of Rights of Residents in AL (NJ State) with focus on "Rights to received [redacted] management as needed". Copies of Resident's Rights distributed on 9/21/23 to residents attending Resident Council, and copies delivered to resident rooms of those who do not attend and was completed by 9/30/23. Copies of "Residents Bill of Rights" included in move-in packet. Residents Rights are prominently displayed in common areas.

4. **HOW THE FACILITY MONITOR IT'S CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR?** Executive director, HWD or its designee to verify and monitor in-service compliance on Resident Bill of Rights (NJ) every week for 1 month, and thereafter as needed. Resident satisfaction surveys, resident council will be used as the monitoring tools.

COMPLETION DATE: 05/15/2023

DEFICIENCY TAG#: A 779

1. **HOW THE CORRRECTIVE ACTION WILL BE ACCOMPLISHED TO THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE?** Resident #2: Pharmacy delivery of oxycodone received 4/27/2023. Administered as per doctor's order. Resident was discharged to Skilled Nursing Facility to be with [redacted] on [redacted] Resident #2: Was seen by primary care physician right after the incident. No new interventions and to continue current medications and treatment plan as per doctor's order.

2. **HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE?** Point Click Care/ e-MAR audited re: residents with [redacted] medications, and 24 hour log report for any residents with complaints of [redacted] change of condition. Audit indicated that no other residents have been affected.

3. **WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WOULD NOT RECUR?** In- serviced all certified medication aides and nurses on: [redacted] Management and Health Service Plan Process. Certified medication aides and nurses reporting procedure on change of condition and complaints of [redacted] and [redacted] to registered nurse on-call and primary care physician. Timely nurse documentation on Point Click Care/ e-mar and 24 hour log. AUDITS?

4. **HOW THE FACILITY MONITOR IT'S CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR?** Executive director, HWD or its designee to monitor in-services compliance weekly for 1 month, and thereafter as needed. Executive director, HWD or designee to ensure review and follow

up of residents with clinical concerns (change of condition, medications availability, notification of 3rd party providers) noted on 24 hour log. Done daily.

COMPLETION DATE: 05/15/2023

DEFICIENCY TAG#: A 781

1. **HOW THE CORRRECTIVE ACTION WILL BE ACCOMPLISHED TO THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE?** Resident #2: was discharged to Skilled Nursing Facility to be [redacted] on [redacted]. Resident #2: Was seen by primary care physician right after the incident. No new interventions and to continue current medications and treatment plan as per treating physician. Developed personalized Health Service Plan on Resident #2 re: [redacted] management both pharmacologic and non-pharmacologic [redacted] interventions. Resident #2: Pharmacy delivery of [redacted] received 4/27/2023. Administered as per doctor's order. Weekly NJ EX Order. 264b1 evaluation started and in place for Resident #2, and other residents on NJ EX Order. 264b1 for [redacted] management.

2. **HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE?** Point Click / e-MAR audited re: residents with [redacted] medications, and 24 hour log for residents with complaints of pain/ change of condition. Audit indicated that no other residents have been affected.

3. **WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WOULD NOT RECUR?** In-serviced all certified medication aide and nurses on proper and timely notification of on-call registered nurse, and primary physician re: resident change of condition, complaint of [redacted] and [redacted], and meds not administered. Residents on pain management will be reviewed bi-weekly during care plan meeting (Collaborative Care Review).

4. **HOW THE FACILITY MONITOR IT'S CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR?** Executive director, HWD or its designee will review and monitor in-service compliance weekly for 1 month. And thereafter as needed. Executive director, HWD or its designee to monitor an ensure compliance on resident care plan meeting/ Collaborative Care Review. Bi-weekly, and ongoing. Executive director, HWD or its designee to verify compliance of registered nurse Health Service Plans and [redacted] review. Monthly and ongoing.

COMPLETION DATE: 05/15/2023

DEFICIENCY TAG#: A 1073

1. **HOW THE CORRRECTIVE ACTION WILL BE ACCOMPLISHED TO THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE?** Resident #2: was discharged to Skilled Nursing Facility to be with [redacted] on [redacted]. Resident #2: Was seen by primary care physician right after the incident. No new interventions and to continue current medications and treatment plan as per primary care physician. Resident #2: Pharmacy delivery of [redacted] received 4/27/2023. Administered as per doctor's order.

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2. **HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE?** Point Click Care/ e-MAR audit indicated that no other residents have been affected.

3. **WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WOULD NOT RECUR?** In-serviced all nurses and certified medication aides on policy and procedures re: Timely and proper documentation on resident progress notes re: health care provider notifications (registered nurse and primary physician). Registered nurse to run a Point Click Care/ e-mar audit report on nursing progress notes compliance. RN to address as needed. Registered nurse or its designee to collect every month and as needed the notes of primary care physician and 3rd party providers' notes and documentation for references and record purposes.

4. **HOW THE FACILITY MONITOR IT'S CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR?** Executive director, HWD or its designee to verify and monitor in-service compliance 1x weekly for 1 month and thereafter as needed. Executive director, HWD or its designee to verify and monitor PCC documentation compliance. 1 x monthly and ongoing.

COMPLETION DATE: 5/15/2023