New Jer	sey Department of H	lealth			FORMA	APPROVED
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE S COMPL	ETED
		04A005	B. WING		C 06/1	7/2019
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BENTLE	YALP		TH ROUTE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROIN DEFICIENCY)	D BE	(X5) COMPLETE DATE
A 000	Initial Comments		A 000			
	Initial Comments: TYPE OF SURVEY	': Monitoring				
	CENSUS: 124					
	SAMPLE SIZE: 7					
	all of the standards Administrative Code Licensure of Assiste Comprehensive Pe Assisted Living Pro submit a plan of con completion date for that the plan is impli- deficiencies may re accordance with pro Administrative Code	e 8:36, Standards for ed Living Residences, rsonal Care Homes and grams. The facility must				
A1505		ving program shall comply provisions in N.J.A.C. 8:36-1	A1505			
	by: A. Based on intervi determined that the with Subchapter 3, required the facility development, imple	NT is not met as evidenced iew and record review it was Administrator failed to comply N.J.A.C. 8:36-3.4(a)(1), which Administrator to ensure the ementation and enforcement of lures, for other residents #'s exerve Coder25.43 and This				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATEMEN	SEY Department of H TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	CONSTRUCTION		E SURVEY PLETED
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING:			
		04A005	B. WING			C 17/2019
NAME OF I	NAME OF PROVIDER OR SUPPLIER STREET AL			TATE, ZIP CODE		
BENTLE	YALP		RTH ROUTE 1 UKEN, NJ 08			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLETE DATE
A1505	Continued From pa	age 1	A1505			
	deficient practice w	as evidenced by the following:				
	observed a report, Consultant Pharma bulletin board in the documented recom	:45 a.m., the surveyor dated 4/30/19, from the acist which was hanging on a e Wellness Center. The report mendations for a total of wing residents were ementation of these	t			
	a. Resident (prn is an abbreviat	is ^{Executive order 26, 440} still needed" tion for as needed.)				
	b. Resident ^{exed} , ^{Executive} term ^{Executive} Greer 20,4 b use	"suggested for long".				
	c. Resident diagnosi	lease evaluate with s."				
	d. Resident ^{Event} "Pl Executive Order 25,4.b.)	lease evaluate ^{Executive Order 26, 4.b.} r 26, 4.b.				
	interviewed the Dire stated that he/she h reports in the past. interviewed the Adr he/she had not sho The surveyor review mentioned resident determined that alt these recommenda	D a.m., the surveyor ector of Nursing (DON) who had never seen the pharmacy The surveyor then ministrator who stated that own these reports to the DON. wed each of the above ts' medical records and hough 6 weeks had elapsed, ations had not been provided e residents' Primary Care				
	the facility policy or	p.m., the surveyor requested a consultant pharmacy reports Administrator that the facility				

New Je	rsey Department of H	lealth			FURIM	APPROVED
STATEME	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
		04A005	B. WING			C 17/2019
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
BENTLE	YALP		RTH ROUTE 1 UKEN, NJ 08 [.]			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
A1505	did not have a policy procedures to be for Pharmacist provide facility. The facility that a policy was de 2. On 6/17/19 at 12 observed prescrip Wellness Center, b Executive Order 26 Executive Order 26, 4 Resident I The surveyor interve that the facility did r followed residents f he/she was not awa had been evaluated the Nursing a both Resident and documented that ea referred to psych." records did not disc the residents had in At 3 p.m., the surver "Intervention of the service Administrator failed 19 day time period were written until th B. Based on record determined that the Subchapter 5, N.J. residents reviewed, which required the service which required the service	y regarding the time frame or illowed when the Consultant d recommendations to the Administrator failed to ensure eveloped and implemented. 2:30 p.m., the surveyor otions on a desk in the oth dated free of the surveyor other and treatment due to b. for Resident and iewed the DON who stated not have anyone who routinely or free order 26,40 and that are whether these residents d. The surveyor then reviewed Assessment documents for nd Resident , which ach "resident has been Further review of the medical close any documentation that		DEFICIENCY		

STATE FORM

JTBU11

If continuation sheet 3 of 5

New Jer	sey Department of H	lealth			FORM	APPROVED	
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		04A005	B. WING			C 06/17/2019	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE			
BENTLE	Y ALP		RTH ROUTE 1 UKEN, NJ 08				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
A1505	Continued From particle well of the survey. Continued From particle well of the survey. C. Based on interviewed the prescriptions on a both dated for the survey. And treatment due for the survey of the survey. and treatment due for the survey of the survey. And treatment due for the survey of the survey. C. Based on interviewed the prescription of the survey. C. Based on interviewed the survey of the survey. C. Based on interviewed the survey.	ge 3 as evidenced by the following: 0 p.m., the surveyor observed a desk in the Wellness Center, for example of the Surveyor N who stated that the facility e who routinely followed model issues and that he/she ther these residents had been veyor then reviewed the essment documents for both rved documented for both esident , "resident has been Further review of the medical close any documentation that n fact been seen. eyor reviewed the facility policy Referral" which documented, n will work with physicians to al services as warranted." The dinate services for the 19 day time period from ption was written until the date iew and record review it was e facility failed to comply with A.C. 8:36-7.5 (e), which to ensure that each resident vical examination in ate regulation, for of of	A1505				
	On 6/17/19 betwee	: #'s marked and this as evidenced by the following: n 10:00 a.m. and 11:00 a.m., red medical records of and and observed the					

If continuation sheet 4 of 5

New Jersey Department of Health						
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMPI	SURVEY LETED
		04A005	B. WING		C 06/1	; 7/2019
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BENTLE	Y ALP		TH ROUTE			
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A1505		-	A1505			
		hysical examinations which red annual physical				
	interview with the A Administrator state physical examination timeline but he/she documentation to c	al dated a move in date of a m				

STATE FORM: REVISIT REPORT

				DATE OF REVIS	SIT
IDENTIFICATION NUMBER	A. Building			1	
04A005 _{Y1}	B. Wing	Y	Y2	7/30/2019	Y3
NAME OF FACILITY	-	STREET ADDRESS, CITY, STATE, ZIP CODE			
BENTLEY ALP		7999 NORTH ROUTE 130			
		PENNSAUKEN, NJ 08110			

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEN	ITEM DATE		ITEM		DATE	ITEM		DATE
Y4		Y5	Y4		Y5	Y4		Y5
ID Prefix	A1505	Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	8:36-23.3(a)	Completed	Reg. #		Completed	Reg. #		Completed
LSC		08/19/2019	LSC		Completed	LSC		
								-
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		-
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		-
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		-
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		-
REVIEWE		REVIEWED BY (INITIALS)	DATE	SIGNATURE OF S	URVEYOR		DATE	
REVIEWE CMS RO	D BY	REVIEWED BY (INITIALS)	DATE	TITLE			DATE	
FOLLOWUP TO SURVEY COMPLETED ON 6/17/2019				FOR ANY UNCORRECT				s 🗆 no

PRINTED: 07/03/2019 FORM APPROVED

STATEMENT	ev Department of Hea FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
÷			A. BUILDING.		с	
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NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STA RTH ROUTE 130			
BENTLEY	ALP)				
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A 000	Initial Comments		A 000			
	Initial Comments: TYPE OF SURVEY: CENSUS: 124	Monitoring				
A1505	all of the standards in Administrative Code & Licensure of Assisted Comprehensive Pers Assisted Living Progr submit a plan of correct completion date for e that the plan is implet	8:36, Standards for Living Residences, onal Care Homes and ams. The facility must action, including a ach deficiency and ensure mented. Failure to correct alt in enforcement action in isions of New Jersey Title 8, Chapter 43E, sure Regulations.	A1505			
		ng program shall comply ovisions in N.J.A.C. 8:36-1 d 23.				
	by: A. Based on interview determined that the A with Subchapter 3, N required the facility Ad development, implem policies and procedur reviewed, Resident #	0				
ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE						

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New Jers	sey Department of Heal	th	1		
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED
7		04A005	B. WING		C 06/17/2019
NAME OF P	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STATE	, ZIP CODE	
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(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
A1505	 On 6/17/19 at 9:45 observed a report, da Consultant Pharmacis bulletin board in the V documented recommendations: a. Resident for implementer recommendations: a. Resident blood term for use." c. Resident for "Pleat diagnosis." d. Resident for "Pleat diagnosis." On 6/17/19 at 11:00 a interviewed the Direct stated that he/she had reports in the past. This interviewed the Admin he/she had not shown The surveyor reviewe mentioned residents' of determined that althout these recommendation by the facility to the reports. On 6/17/19 at 3:30 p.r 	evidenced by the following: a.m., the surveyor ted from the st which was hanging on a Vellness Center. The report endations for a total of ing residents were entation of these prn still needed" a for as needed.) I work "suggested for long se evaluate with se evaluate meds ds for meds ds for meds ds for meds d. m., the surveyor or of Nursing (DON) who d never seen the pharmacy he surveyor then histrator who stated that a these reports to the DON. d each of the above medical records and ugh weeks had elapsed, ns had not been provided esidents' Primary Care m., the surveyor requested	A1505		
	the facility policy on co	onsultant pharmacy reports dministrator that the facility			

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Sey Department of Hea FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
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did not have a policy procedures to be follo Pharmacist provided facility. The facility A that a policy was dev 2. On 6/17/19 at 12: observed 2 prescripti Wellness Center, bot Resident . The surveyor intervie that the facility did no followed residents for he/she was not awar had been evaluated. the Nursing A both Resident and documented that each referred to	regarding the time frame or owed when the Consultant recommendations to the administrator failed to ensure reloped and implemented. 30 p.m., the surveyor ions on a desk in the th dated for and treatment due to for Resident for and treatment due to for Resident for wed the DON who stated ot have anyone who routinely resident fissues and that e whether these residents The surveyor then reviewed ssessment documents for d Resident which th "resident has been further review of the medical bee any documentation that fact been seen. or reviewed the facility policy, "," which documented, "Our brk with physicians to obtain es as warranted." The o enforce this policy for the om the time the prescriptions date of this survey. review and interview it was acility failed to comply with .C. 8:36-5.1(a), for for Resident and Resident cility to coordinate personal	A1505	DEFICIEN		
	Continued From pag did not have a policy procedures to be foll Pharmacist provided facility. The facility A that a policy was dev 2. On 6/17/19 at 12: observed 2 prescripti Wellness Center, bot Resident . The surveyor intervie that the facility did no followed residents fo he/she was not awar had been evaluated. the Nursing A both Resident and documented that eac referred to . Frecords did not discle the residents had in f At 3 p.m., the survey "Psychology Referral wellness team will we psychological service Administrator failed t 19 day time period fr were written until the B. Based on record a determined that the f Subchapter 5, N.J.A residents reviewed, F which required the fa care and services ba	OF DEFICIENCIES OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: O4A005 04A005 ROVIDER OR SUPPLIER STREET A 7999 NC PENNSA ALP 7999 NC PENNSA SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 2 did not have a policy regarding the time frame or procedures to be followed when the Consultant Pharmacist provided recommendations to the facility. The facility Administrator failed to ensure that a policy was developed and implemented. 2. On 6/17/19 at 12:30 p.m., the surveyor observed 2 prescriptions on a desk in the Wellness Center, both dated for Resident and treatment due to for Resident and treatment for mand treatment due to for Resident and treatment for bollowed residents for support issues and that he/she was not aware whether these residents had been evaluated. The surveyor then reviewed the Nursing Assessment documents for both Resident and Resident which documented that each "resident has been	CODEFICIENCIES (X1) PROVIDER/SUPPLIER/CLA (X2) MULTIPLE C DENTIFICATION NUMBER: A.BUILDING:	OPE DEFICIENCIES (X1) PROVIDERSUPPLIERCIAL DENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING: ORADOS B. WING ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE. ZIP CODE ALP 7999 NORTH ROUTE 130 PENNSAUKEN, NJ 08110 (BACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY ON LSC IDENTIFYING INFORMATION) IP (BACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY ON LSC IDENTIFYING INFORMATION) IP Continued From page 2 A1505 did not have a policy regarding the time frame or procedures to be followed when the Consultant Pharmacist provided recommendations to the facility. The facility Administrator failed to ensure that a policy was developed and implemented. A1505 2. On 6/17/19 at 12:30 p.m., the surveyor observed 2 prescriptions on a desk in the Wellness Center, but dated For Resident for for Resident for that the facility did not have anyone who routinely followed residents for that the facility did not have anyone who routinely followed resident for the surveyor interviewed the DON who stated that the facility did not have anyone who routinely followed resident for method and realised to bothin documented that each "resident has been reformed to disclose any documentation that the residents had in fact been seen. A1 3 p.m., the surveyor reviewed the facility policy, "Psychology Referral," which documented, "Our wellness team will work with physicians to obtain psychological services as warranted." The Administrator failed to enforce this policy for the 19 day time period from the time the prescingtions were written until the date of this survey. </td <td>OPE DEFICIENCIES (M1) PROVIDERSUPPLIERCLA DENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BULDING: </td>	OPE DEFICIENCIES (M1) PROVIDERSUPPLIERCLA DENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BULDING:

STATE FORM

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		s evidenced by the following:					
	2 prescriptions on a c both dated and treatment due to Resident and Res interviewed the DON did not have anyone residents for was not aware wheth evaluated. The surve Nursing Asses residents and observ Resident and Res referred to record F records did not disclo the residents had in f	ident The surveyor who stated that the facility who routinely followed and that he/she er these residents had been eyor then reviewed the ssment documents for both ed documented for both ident The "resident has been urther review of the medical ose any documentation that fact been seen.					
	titled, "Psychology Re "Our wellness team v obtain psychological DON failed to coordir these residents for th	or reviewed the facility policy eferral" which documented, vill work with physicians to services as warranted." The nate the services for e day time period from ion was written until the date					
	determined that the fa Subchapter 7, N.J.A. required the facility to have an annual physi accordance with state residents, Resident #	e regulation, for of					
	On 6/17/19 between the surveyor reviewee Resident #'s	10:00 a.m. and 11:00 a.m., d medical records of and observed the					

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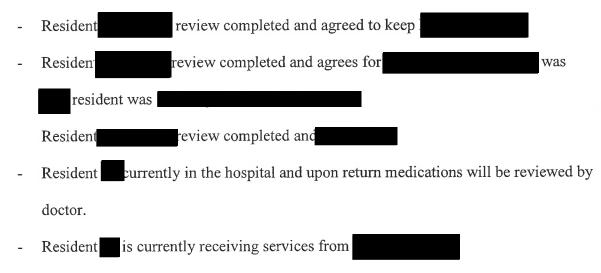
New Jers	New Jersey Department of Health							
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:	ONSTRUCTION	(X3) DATE SURVEY COMPLETED			
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NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE				
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DENTEET			AUKEN, NJ 08110					
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A1505	Continued From page	e 4	A1505					

PLAN OF CORRECTION RESPONSES FOR June 17, 2019

ID Prefix Tag NJAC 8:36-3.4(a)(1)

Plan of Correction Date: 8/19/19

 How the corrective action will be accomplished for those residents found to have been affected by the deficient practice; these are the residents specified in the Statement of Deficiencies (SOD).



- Resident was referred to for services.
- 2. How the facility will identify other residents having the potential to be affected by the same deficient practice.
 - All residents have the potential to be effected by this deficient practice.
- 3. What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur.

- Consultant Pharmacist recommendations have been given to resident's APN, Doctor for review for approval or decline.
- New Policy was developed for consultant pharmacy recommendations and in-service with nursing department.

Nursing staff in-serviced on sending resident that has prescription for psych service to helping hands or behavior health for services

- 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not occur, i.e. what program will be put in place to monitor the continued effectiveness of the systemic change.
 - Nursing will bring completed Pharmacy report to QA meeting. Random audits by ED or DON will be completed for compliance prescription for psych services.

NJAC 8:36-5.1(a)

Plan of Correction Date: 8/19/19

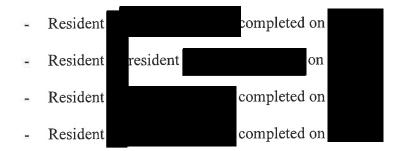
- How the corrective action will be accomplished for those residents found to have been affected by the deficient practice; these are the residents specified in the Statement of Deficiencies (SOD).
 - Resident is currently receiving services from
 - Resident referred to for services
- 2. How the facility will identify other residents having the potential to be affected by the same deficient practice.

- a. All residents have the potential to be effected by this deficient practice.
- What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur.
 - a. Consultant Pharmacist recommendations have been given to resident's APN,
 Doctors for review for approval or decline.
 - b. New Policy was developed and in-service with nursing department.
 - c. Nursing staff in-serviced on sending residents that have a prescription for service to for services.
- 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not occur, i.e. what program will be put in place to monitor the continued effectiveness of the systemic change.
 - Consultant Pharmacist recommendations will be brought to QA for review and completion.
 - ED and RN will meet weekly to discuss any new psych services needed for residents.

ID Prefix Tag NJAC 8:36-7.5(e)

Plan of Correction Date: 8/19/19

- How the corrective action will be accomplished for those residents found to have been affected by the deficient practice; these are the residents specified in the Statement of Deficiencies (SOD).
 - Resident completed on



- 2. How the facility will identify other residents having the potential to be affected by the same deficient practice.
 - All residents have the potential to be effected by this deficient practice.
- What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur.
 - All charts were audited and spread sheet implemented with all resident dates for Annual Physicals.
 - The doctors have been given the paper work to complete for all out dated physical examinations.
- 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not occur, i.e. what program will be put in place to monitor the continued effectiveness of the systemic change.
 - ED or DON will audit five random charts for compliance with annual physicals quarterly and report to QA.