STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04A005	A. BUILDING: _____ B. WING _____	06/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENTLEY COMPREHENSIVE CARE LLC	7999 NORTH ROUTE 130 PENNSAUKEN, NJ 08110

(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
A 000	Initial Comments Initial Comments: A Life Safety Code Survey was conducted by the State Agency on 06/07/2023. The facility was found not to be compliance with New Jersey Administrative Code, Chapter 8:36, Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes, and Assisted Living Programs. TYPE OF SURVEY: Standard CENSUS: 59 CAPACITY: 200 SAMPLE SIZE: 8 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 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;	A 310		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 07/07/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 310	Continued From page 1	A 310		

This REQUIREMENT is not met as evidenced by:
Based on interview and record review it was determined that the facility's Administrator failed to implement and enforce the facility's policy and procedure titled, "Personal Needs Allowance." This deficient practice was evidenced by the following:

On 6/7/2023 at 10:01 a.m., during a standard survey, the surveyor interviewed Resident #8 who stated that he/she did not receive his/her Personal Needs Allowance (PNA) on the NJ Exec Order [redacted] and was not aware of when PNA funds were being dispensed by the facility to the residents. Surveyor review of Resident #8's Medical Record (MR) revealed he/she moved in on NJ Exec Order 26.4b1 with diagnoses which included NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 [redacted]

At 11:59 a.m., the surveyor interviewed Resident #7 who stated he/she did not receive PNA funds for the month of NJ Exec Order 26.4b1 and was not aware of when PNA funds were dispensed. Surveyor review of Resident #7's MR revealed Resident he/she moved in on NJ Exec Order 26.4b1 with diagnoses which included NJ Exec Order 26.4b1 and

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A 310	Continued From page 2 NJ Exec Order 26,48 At 12:30 p.m., the surveyor interviewed the facility's Business Office Manager (BOM) who stated residents who chose to have their PNA funds dispensed through the facility's business office were instructed to obtain and complete a PNA withdrawal form and submit the completed PNA withdrawal form to the facility's front desk receptionist. The BOM stated that every Thursday she withdraws the amount of PNA funds requested for withdrawal from a local community bank and dispenses it to the resident. At 12:52 p.m., the surveyor conducted a follow up interview with the facility's BOM who stated that there was no documentation that contained residents' signatures to acknowledge the receipt of requested funds at the time of disbursement. Surveyor review of the facility's policy and procedure titled, "Personal Needs Allowance" revealed, "Policy and Procedure: It is the Residence policy to responsibly hold any money that is entrusted to the home in accounts with easy access and to be able to provide residents with information about their accounts with the home ... 2. Written records shall be maintained, such as a ledger, including the date each payment was received, the amount of payment, the date of each disbursement, the reason for each disbursement, and to whom the disbursement was made. 3. The resident shall sign to acknowledge the receipt of funds, goods, or services purchased with such funds at the time of disbursement ..."	A 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A1211	Continued From page 3	A1211		
A1211	8:36-17.3(b)(1) Housekeeping-Sanitation-Safety-Maintenance (b) The following safety conditions shall be met: 1. Non-carpeted floors in public areas shall be coated with slip-resistant floor finish, and any carpeting in public areas shall be kept clean and odor free and shall not be frayed, worn, torn, or buckled; This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to provide carpeting in public areas that was not frayed, worn, torn, or buckled. Findings included: During an observation and concurrent interview on 06/07/2023 at 11:34 AM, observation of the carpeting in the main corridor on the second floor of the facility revealed a 20-foot-long by 3-foot-wide section of the carpeting missing. The Director of Environmental Services stated he was unaware of the condition of the carpeting. The Director of Maintenance stated the facility did not have a policy regarding environmental surveillance rounds. During an observation and concurrent interview on 06/07/2023 at 11:29 AM, observation of the carpeting in the main corridor on the third floor of	A1211		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04A005	A. BUILDING: _____ B. WING _____	06/07/2023

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BENTLEY COMPREHENSIVE CARE LLC	7999 NORTH ROUTE 130 PENNSAUKEN, NJ 08110

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A1211	Continued From page 4 the facility revealed a 20-foot-long by 3-foot-wide section of the carpeting missing. The Director of Environmental Services stated he was unaware of the condition of the carpeting. The Director of Maintenance stated the facility did not have a policy regarding environmental surveillance rounds.	A1211		
A1249	8:36-17.7 Housekeeping-Sanitation-Safety-Maintenance The building and grounds shall be well maintained at all times. The interior and exterior of the building shall be kept in good condition to ensure an attractive appearance, provide a pleasant atmosphere, and safeguard against deterioration. The building and grounds shall be kept free from fire hazards and other hazards to resident's health and safety. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure the building and grounds were kept free from fire hazards and other hazards to residents' health and safety. Findings included: During an observation and concurrent interview on 06/07/2023 at 11:25 AM, the overhead lighting fixture in the fire escape stairway landing on the	A1249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04A005	A. BUILDING: _____ B. WING _____	06/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A1249	Continued From page 5 fourth floor adjacent to Resident Room [redacted] was missing, not complying with the standard set forth by the National Fire Protection Association (NFPA) 101 section 7.2.2.5.5.11 (2) that requires that the illumination remain on when the building is occupied. The Director of Environmental Services stated he was unaware that the condition observed by the surveyor existed. The Director of Maintenance stated the facility did not have a policy regarding environmental surveillance rounds.	A1249		

07/07/2023

Re: Bentley ALP POC for Survey on 6/7/2023

Hello,

Please accept the enclosed Plan of Correction for Bentley ALP License# 04A005.

Kind Regards,

NJ Exec Order 26.4b1 ALP Administrator License# (AL200038211)

Bentley ALP
NJ#04A005
7999 North Route 130
Pennsauken, New Jersey 08110

Complaint(s) of Survey visit dated: 06/07/2023.

The plan of correction is the facility's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute an admission or agreement by the providers of the truth or the fact alleged, or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and or/ executed solely because it is required by the provision of the New Jersey State Department of Health.

ID Tag A310: NJAC 8:36-3.4(a)(1)

1. Immediate
As of June 26, 2023, the corrective action was accomplished as the Business Office Manager (BOM) has been re-educated by the Administrator regarding the facility's policy and procedures for "Personal Needs Allowance" (PNA).

Resident #8, along with all other residents, resident #8 was notified of the changes regarding Personal Needs Allowance (PNA) distribution and assured that their funds will be received upon 72 hours of requested (per) NJDHSS Assisted Living Regulations.

Resident #7, along with all other residents, resident #7 was notified of the changes regarding Personal Needs Allowance (PNA) distribution and assured that their funds will be received upon 72 hours of request (per) NJDHSS Assisted Living Regulations.

A "PNA" notification for all residents was posted on 7/14/2023.

2. Identifications of Others
To identify and avoid the possibility of other residents being affected, the Administrator and BOM will review all criteria required for proper distribution of Personal Needs Allowance (PNA), as per the NJDHSS Assisted Living Regulations. All residents have the ability to be affected.

This was completed on June 29, 2023.

3. Systemic Changes
The BOM/Designee will post "PNA" updates and/or reminders for all residents on a weekly basis. In addition to the withdrawal forms, the BOM/Designee will utilize the "PNA" receipt feature provided by the "PNA" system for all residents to sign upon receiving the requested PNA. The BOM will collect, and file all signed PNA receipts with the end of month financials for reference.

4. Quality Assurance
The Administrator will review the end of month financials to ensure that the “PNA” policy and procedures are being followed accordingly. Additionally, an annual audit will be conducted by the Administrator/Designee to maintain compliance within the NJDHSS Assisted Living Regulations. This will be reviewed at the quarterly QA meeting in September and ongoing.

Completion Date 07/14/2023.

ID Tag A1211: 8:36-17.3(b)(1)

1. Immediate
On 7/6/2023, The corrective actions taken was the construction staff and the Maintenance Director removed all worn, torn or buckling carpeting. All loose edges were taped down to the best of their ability to assure the residents safety while occupying the second and third floor. On July 6, 2023, caution postings are visibly available to alert residents of the current floor renovations that are ongoing.

The second and third floors are estimated to be complete by October 1, 2023.

2. Identifications of Others
The Maintenance Director/Designee will monitor the second and third floor carpet daily to ensure that the temporary repairs are maintained, and caution posting are visibly available to residents, staff, and guests. All residents have the ability to be affected.

3. Systemic Changes
On NJ Exec Order 26.4b1, Oasis hired a new Maintenance Director. The Maintenance Director has been provided with a complete copy of the Plant and Maintenance policy and procedures to always reference.

The Administrator implemented a new Safety Committee on 6/14/2023 to assist with maintaining the safety in the facility.

4. Quality Assurance
The Maintenance Director/Designee will conduct daily environmental rounds using the Safety Committee “Safety Inspection Form” to ensure the residents safety. This will be reviewed at the next quarterly QA meeting in September 2023 and ongoing.

Completion Date 07/6/2023.

ID Tag A1249: 8:36-17.7

1. Immediate
The corrective action was accomplished as the Maintenance Director repaired the lighting fixture in the fire escape stairway on 6/10/2023.

2. Identifications of Others
The Maintenance Director/Designee will monitor all safety hazards daily to ensure the residents health and safety. The Maintenance Director/Designee will utilize the “Safety Inspection Form” to assist with the daily safety hazard checks. All residents have the ability to be affected.

3. Systemic Changes
In the absence of the Maintenance Director, the Maintenance Assistant or Housekeeping Supervisor will complete the safety hazard checks and report any findings to the Maintenance Director via email. This will be updated in the facility’s policy and procedures binder on 7/10/2023.

4. Quality Assurance
The daily safety hazard checks will be implemented on July 10, 2023. This will be reviewed at the next quarterly QA meeting in September 2023 and ongoing.

Completion Date 06/10/2023.

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
04A005 Y1	A. Building B. Wing Y2	8/7/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BENTLEY COMPREHENSIVE CARE LLC	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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A0310	Correction	ID Prefix A1211	Correction	ID Prefix A1249	Correction
Reg. # 8:36-3.4(a)(1)	Completed	Reg. # 8:36-17.3(b)(1)	Completed	Reg. # 8:36-17.7	Completed
LSC	07/14/2023	LSC	07/06/2023	LSC	06/10/2023
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	

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	
6/7/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO