

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>04A005</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/26/2020</b>
NAME OF PROVIDER OR SUPPLIER  <b>BENTLEY COMPREHENSIVE CARE LLC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>7999 NORTH ROUTE 130</b> <b>PENNSAUKEN, NJ 08110</b>		
(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	<p>Initial Comments</p> <p>Initial Comments: TYPE OF SURVEY: Complaint and COVID-19 Focused Infection Control COMPLAINT #: NJ00134019 CENSUS: 99 SAMPLE SIZE: 4 SURVEY DATE: 10/26/2020</p> <p>The facility was 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, based on this Complaint Survey.</p> <p>The facility was found not to be in compliance with the New Jersey Administrative Code 8:36 infection control regulations standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes and Assisted Living Programs, based on this <span style="background-color: black; color: white;">NJ Ex Order 26.4(b)(1)</span> Focused Infection Control Survey.</p> <p>This 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.</p>	A 000		
A 315	<p>8:36-3.4(a)(5) Administration</p> <p>(a) The administrator or designee shall be responsible for, but not limited to, the following:</p> <p>5. Establishing and maintaining liaison relationships and communication with facility staff and services and with</p>	A 315		

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

TITLE

(X6) DATE

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A 315	<p>Continued From page 1</p> <p>residents and their families;</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and facility policy review, the Administrator failed to provide weekly communication/updates to residents' families regarding the facility's <b>NJ Ex Order 26.4b1</b> status. This had the potential to affect all 99 residents in the facility who received Assisted Living Program services.</p> <p>Findings included:</p> <p>The facility's "Outbreak Response Plan COVID-19 NJ," indicated: "...Communications and Updates...Families will receive a weekly notification from our community during curtailed visitation."</p> <p>On 10/26/2020 at 9:00 AM, signage was posted on the entrance of the facility which indicated visitation was limited.</p> <p>On 10/26/2020 at 1:27 PM, the Administrator was interviewed. When asked if the facility provided weekly communication/updates regarding the facility's <b>NJ Ex Order 26.4b1</b> status to residents' families, she stated families were notified only when a <b>NJ Ex Order 26.4b1</b> case occurred. When asked if visitors were allowed in the facility, she stated only essential medical personnel were allowed in the facility.</p>	A 315		
A1297	8:36-18.3(a)(4) Infection Prevention and Control Services	A1297		

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A1297	<p>Continued From page 2</p> <p>(a) Written policies and procedures shall be established and implemented regarding infection prevention and control, including, but not limited to, policies and procedures for the following:</p> <p>4. Surveillance techniques to minimize sources and transmission of infection;</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and facility policy review, the facility failed to screen residents daily for signs and symptoms of [NJ Ex Order 26.4b1] as part of their infection control and prevention surveillance plan. This had the potential to affect all 99 residents in the facility who received Assisted Living Program services.</p> <p>Findings included:</p> <p>The facility's "Outbreak Response Plan COVID-19 NJ," indicated: "...General Preparedness for Emergent Infectious Diseases...The community's infection control program will include a response plan for community wide infectious disease outbreak such as pandemic influenza. This plan will...include administrative controls (screening, isolation...)"</p> <p>On 10/26/2020 at 10:15 AM, the Infection Control Coordinator was asked if residents were screened daily for signs and symptoms of [NJ Ex Order 26.4b1]. She stated, "When [NJ Ex Order 26.4b1] was active, [residents' temperatures] were taken daily. Now, only residents who have a physician's order for vital signs had their [temperature] taken."</p>	A1297		

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A1297	Continued From page 3  On 10/26/2020 at 5:23 PM, the Infection Control Coordinator was asked again about residents being screened for signs and symptoms of [REDACTED] NJ Ex Order 26.4b1. She stated residents were not screened for signs and symptoms of [REDACTED] NJ Ex Order 26.4b1. She stated a resident's vital signs would not be taken unless the resident complained they were [REDACTED] NJ Ex Order 26.4(b)(1).	A1297			

# STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 04A005	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 12/29/2020
NAME OF FACILITY BENTLEY COMPREHENSIVE CARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 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 A0315	Correction	ID Prefix A1297	Correction	ID Prefix	Correction
Reg. # 8:36-3.4(a)(5)	Completed	Reg. # 8:36-18.3(a)(4)	Completed	Reg. #	Completed
LSC	10/30/2020	LSC	11/20/2020	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	
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 10/26/2020		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO			