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 _____	C 10/05/2020

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: TYPE OF SURVEY: Complaint COMPLAINT #: NJ00139901 CENSUS: 85 SAMPLE SIZE: 3 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 11/06/20

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 This REQUIREMENT is not met as evidenced by: Complaint #: NJ00139901 Based on interview and review of pertinent facility documents it was determined that the Administrator failed to enforce the facility's policy titled, "Narcotic Policy, Count & Storage" which required the Nurses or Certified Medical Assistant (CMA) to count narcotics at the change of each shift. This deficient practice was evidenced by the following: Review of a Facility Reportable Event (FRE) dated and faxed to the Department of Health (DOH) on 9/30/20 and the facility's "Investigation and Investigative Summary," identified that the facility lost accountability of 30 tablets of Oxycodone HCL 5 milligram (mg) tablet and 22 tablets of clonazepam 0.5 mg which was identified during a narcotic medication count at the change of shift on 9/29/20 at 11:00 p.m. The surveyor visited the facility on 10/5/20 and met with the Executive Director (ED) who stated that on 9/30/20 at 12:45 a.m., she received a call from the Licensed Practical Nurse (LPN) #1 who reported that there were two bingo cards (a drug delivery system used to package unit doses) of narcotics missing. The ED stated that LPN #1 told her that at the start of his shift at 3:00 p.m. that he [LPN #1] did not count with the Certified Medication Aide (CMA) before she left the facility.	A 310		

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A 310	Continued From page 2 The ED further stated that the Nurses and CMA's are supposed to count narcotics at the change of each shift. On 10/5/20 at 12:30 p.m., the surveyor interviewed the CMA who stated on 9/29/20 that she did not do a narcotic medication count with LPN #1. The CMA also stated that she did not inform the Director of Nursing (DON) that she failed to do a narcotic count at the end of her shift before she left the facility. The CMA also stated she received a call from LPN #1 on 9/30/20 around 12:15 a.m. and was informed that there were two bingo cards missing. On 10/5/20 at 1:45 p.m., along with the ED the surveyor interviewed LPN #1 via telephone conference call and he stated that he usually does a narcotic count at the change of shift but on 9/29/20 he did not count the narcotics at the change of shift. On 10/6/20 the surveyor interviewed via telephone LPN #2 who discovered the missing narcotics when she did a narcotic count on 9/29/20 with LPN #1. LPN #2 further stated that she always does a narcotic count and when the medications were discovered missing, she did not accept the medication cart keys and informed LPN #1 to notify the ED and the DON of the two missing bingo cards. The surveyor reviewed the facility's policy titled, "Narcotic Policy, Count & Storage which revealed, "...Nurses and MNAs [CMAs] are responsible for	A 310		

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A 310	Continued From page 3 counting the narcotics at the charge of shift." The facility failed to follow its policy by not counting the narcotics at the change of shift.	A 310		
A 407	8:36-4.1(a)(25) 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 to the following rights: 25. The right to keep and use his or her personal property, unless this would be unsafe, impractical, or an infringement on the rights of other residents. The facility shall take precautions to ensure that the resident's personal possessions are secure from theft, loss, and misplacement; This REQUIREMENT is not met as evidenced by: Complaint #: NJ00139901 Based on interview and record review it was determined that the facility failed to ensure that the resident's personal possessions which included NJ Ex Order 26.4(b)(1) was secured from theft, loss and/or misplacement for 2 of 3 residents reviewed, Resident #1 and Resident #2. This deficient practice was evidenced by the following: The Department of Health (DOH) received a facility reportable event (FRE) on 9/30/20 which	A 407		

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A 407	Continued From page 4 revealed that NJ Ex Order 26.4(b) were missing from the facility's medication cart. The FRE indicated that a bingo card (a drug delivery system used to package unit doses) of NJ Ex Order 26.4(b)(1) contained NJ Ex tablets and a bingo card of NJ Ex Order 26.4(b)(1) contained NJ Ex tablets were missing and unaccounted for during a NJ Ex Order 26.4 medication count at the change of shift on NJ Ex Order 26.4 at 11:00 p.m. On 10/5/20 at 10:00 a.m., the surveyor reviewed the medical record of Resident #1 which revealed the resident moved into the facility on NJ Ex Order 26.4 with diagnoses which included NJ Ex Order 26. , NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4 The surveyor observed that Resident #1 had a written prescription dated NJ Ex Order 26.4 for NJ Ex Order 26.4(b)(1) , to be administered by mouth every four hours as needed for NJ Ex days for NJ Ex Order 26.4(b)(1). Later that day the surveyor reviewed the medical record of Resident #2 which revealed that the resident moved into the facility on NJ Ex Order 26.4 with a diagnosis which included NJ Ex Order 26.4(b)(1) , NJ Ex Order 26. and NJ Ex Order 26.4(b)(1) The surveyor observed Resident #2's Medication Administration Record (MAR) which revealed that the resident had an order for NJ Ex Order 26.4(b)(1) take a NJ Ex Order 26.4(b)(1) twice daily as needed for NJ Ex Order 26.4 On 10/5/20 at 12:40 p.m., the Registered Nurse (RN) stated that during the medication count on NJ Ex Order 26.4 at 11:00 p.m. it was discovered that the medications were missing and they were not found.	A 407		

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A 407	Continued From page 5 The RN also stated that on [NJ Ex Order 26.4] at 3:00 p.m., the Licensed Practical Nurse did not perform a [NJ Ex Order 26.4] count at the change of shift to ensure the accuracy of the [NJ Ex Order 26.4] medications. The RN further stated that Resident #1 and Resident #2 was on the medication program and that the facility was responsible for the storage and safe keeping of the resident's medications.	A 407		
A1011	8:36-11.7(k) Pharmaceutical Services (k) Controlled dangerous substances shall be stored, and records shall be maintained, in accordance with the Controlled Dangerous Substances Acts, N.J.S.A. 24:21-1 et seq. and all other Federal and State laws and regulations concerning the procurement, storage, dispensation, administration, and disposition of same. This REQUIREMENT is not met as evidenced by: Complaint : NJ00139901 Based on interview and record review, it was determined that the facility failed to ensure that the Licensed Practical Nurse (LPN) and the Certified Medication Aides (CMA) were performing a shift to shift count of a [NJ Ex Order 26.4(b)(1)] in order to maintain accountability in accordance with facility policy for 2 of 3 residents reviewed, Resident #1 and Resident #2. This deficient practice was evidenced by the following:	A1011		

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A1011	Continued From page 6 Review of a Facility Reportable Event (FRE) record dated and faxed to the Department of Health (DOH) on [NJ Ex Order 26.4] and the facility's "Investigation and Investigative Summary" identified that the facility lost accountability of [NJ Ex] tablets of NJ Ex Order 26.4(b)(1)) and [NJ Ex] tablets of NJ Ex Order 26.4(b)(1) which was identified during a [NJ Ex Order 26.4] medication count at the change of shift on 9/29/20 at 11:00 p.m. On 10/5/20 at 10:00 a.m., the surveyor reviewed the medical record of Resident #1 which revealed the resident moved into the facility on [NJ Ex Order 26.4] with diagnoses which included [NJ Ex Order 26.] , NJ Ex Order 26.4(b)(1) , [NJ Ex Order 26.4(b)(1)] and [NJ Ex Order 26.4] The surveyor observed a copy of the written prescription dated [NJ Ex Order 26.4] for NJ Ex Order 26.4(b)(1)), to be administered by mouth every four hours as needed for [NJ Ex] days for NJ Ex Order 26.4(b)(1). Later that day the surveyor reviewed the medical record of Resident #2 which revealed that the resident moved into the facility on [NJ Ex Order 26.4] with a diagnosis which included NJ Ex Order 26.4(b)(1), [NJ Ex Order 26.] and [NJ Ex Order 26.4(b)(1)] The surveyor observed Resident #2's Medication Administration Record (MAR) which included NJ Ex Order 26.4(b)(1), twice daily as needed for [NJ Ex Order 26.4] The surveyor reviewed Resident #1 declining inventory sheet (DIS) for the NJ Ex Order 26.4(b)(1) and observed that [NJ Ex O] tablets were received on [NJ Ex Order 26.] from the pharmacy. The DIS further indicated that on [redacted] at 11:00 a.m., Resident #1 received a dose of [NJ Ex Order 26.4(b)(1)] with a remainder of [NJ Ex O] tablets and on [NJ Ex Order 26.4] at 4:15 p.m. the resident received another dose of [NJ Ex Order 26.4(b)(1)] with a remainder of [NJ Ex O] tablets and another dose at 8:15 p.m., with a remainder of	A1011		

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A1011	Continued From page 7 NJ Ex O tablets. Further review of the DIS indicated that on NJ Ex Order 26.4 at 8:21 a.m., the resident received one tablet of NJ Ex Order 26.4(b)(1) with the remainder of 87 tablets, which revealed NJ Ex tablets were unaccounted for and missing. The surveyor reviewed the DIS for Resident #2 which revealed NJ Ex Order 26.4(b)(1) with a remainder of NJ Ex tablets in the bingo card (a drug delivery system used to package unit doses), the entire bingo card was missing. On 10/5/20 at 12:00 p.m., during interview with the Executive Director (ED) she stated that LPN #1 discovered the missing medications during the change of shift on [redacted] at 11:00 p.m. The ED further stated that LPN #1 and the CMA did not do a NJ Ex Order 26.4 count at the change of shift on NJ Ex Order 26.4 at 3:00 p.m. when he [LPN #1] arrived at the facility. The ED stated that after the investigation she was unsure what happened to the missing medications. The ED, further stated that the shift to shift count should have included a NJ Ex Order 26.4 count by the incoming and outgoing CMA's or LPN's for verification of the quantity of NJ Ex Order 26.4(b) that remained in NJ Ex Order 26.4 drawer. On 10/5/20 at 12:30 p.m., the surveyor interviewed the CMA who stated that on NJ Ex Order 26.4 at the end of her shift she did not perform a NJ Ex Order 26.4 count with LPN #1 and that she did not inform the Registered Nurse (RN) that she failed to do a NJ Ex Order 26.4 count. The CMA further stated that on 9/30/20 around 12:45 a.m. she received a call from LPN #1 stating that there were two bingo cards missing from the NJ Ex Order 26.4 drawer which included	A1011		

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A1011	Continued From page 8 NJ Ex Order 26.4(b)(1) for Resident #1 and NJ Ex Order 26.4(b)(1) for Resident #2. On 10/5/20 at 12:40 p.m., the surveyor interviewed the RN who stated that at the change of shifts the LPN's or CMA's are supposed to do a NJ Ex Order 26.4 count to ensure accuracy and accountability of each medication. The RN further stated that the CMA and LPN #1 did not do a NJ Ex Order 26.4 count at the change of shift on NJ Ex Order 26.4 at 3:00 p.m. On 10/5/20 at 1:45 p.m., the surveyor interviewed LPN #1 who stated that he did not do a NJ Ex Order 26.4 count at the start of his shift on NJ Ex Order 26.4 at 3:00 p.m., and that the medications were discovered missing when he performed a NJ Ex Order 26.4 count with LPN #2, who works the 11:00 p.m. - 7:00 a.m., shift. LPN #1 further stated that they looked for the bingo cards in the medication carts but did not find them. LPN #1 also stated that he was the only one who had possession of the medication cart keys during his shift. LPN #1 further stated that he called the ED and the RN to inform them of the missing NJ Ex Order 26.4 medications. On 10/6/20 at 12:17 p.m., the surveyor interviewed LPN #2 who worked the 11:00 p.m. - 7:00 a.m. shift on NJ Ex Order 26.4 and she stated that the two bingo cards were discovered missing when she performed a NJ Ex Order 26.4 count with LPN #1. LPN #2 also stated that she did not accept the keys and informed her coworker [LPN #1] to call the ED and the RN to inform them of the missing medications. The surveyor reviewed the facility's policy titled, "Narcotic Policy, Count & Storage which revealed, "...Nurses and MNAs [CMAs] are responsible for counting the narcotics at the charge of shift."	A1011		

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A1013	8:36-11.7(l) Pharmaceutical Services (l) Any theft of Scheduled or Controlled Substances shall be reported to the New Jersey Department of Law and Public Safety, Division of Consumer Affairs, Enforcement Bureau of Professional Boards at (973) 504-6300, and/or to any other municipal, county, State, or Federal authority having jurisdiction over theft of such substances. This REQUIREMENT is not met as evidenced by: Complaint #: NJ00139901 Based on interviews, review of medical records and other pertinent facility documents, it was determined that the facility failed to immediately report the theft of a NJ Ex Order 26.4(b)(1) for Resident #1 and Resident #2 to the New Jersey Department of Law and Public Safety, Division of Consumer Affairs, Enforcement Bureau of Professional Boards having jurisdiction over theft of controlled substances. This deficient practice was based on the following: Review of a Facility Reportable Event Record dated and faxed to the Department of Health (DOH) on NJ Ex Order 26.4 and the facility's "Investigation and Investigative Summary" revealed that the facility lost accountability of NJ Ex NJ Ex Order 26.4(b)(1)) tablet and NJ Ex Order 26.4(b)(1) tablets which was identified during a NJ Ex Order 26.4 medication count at the change of shift on NJ Ex Order 26.4 at 11:00 p.m. On 10/5/20, the surveyor visited the facility and met with the Executive Director (ED) who	A1013		

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A1013	Continued From page 10	A1013		

confirmed that there were missing medications which was discovered during the change of shift and NJ Ex Order 26.4(count on NJ Ex Order 26.4 at 11:00 p.m. The ED stated that the Licensed Practical Nurse (LPN) called her around on NJ Ex Order 26.4 at 12:45 a.m. and told her that there were 2 bingo cards (a drug delivery system used to package unit doses) missing from the medication cart. The ED stated that she was informed by LPN #1 that Resident #1 was missing a bingo card which contained NJ Ex tablets of NJ Ex Order 26.4(b)(1) and Resident #2 was missing a bingo card which contained NJ Ex tablets of NJ Ex Order 26.4(b)(1) The ED further stated that she instructed the LPN to recheck the medication carts. The ED also stated LPN #1 informed her that he did not count with the Certified Medication Aide (CMA) when his shift began at 3:00 p.m. The ED stated that she asked LPN #1 if the cart was left unlocked at any time and he replied, "No."

The ED stated that on NJ Ex Order 26.4 when she arrived at the facility, she checked the medication carts and did not find the missing NJ Ex Order 26.4(medications. The ED also stated that the Director of Nursing (DON) was notified of the missing medications on NJ Ex Order 26.4 by LPN #1.

The ED stated that on NJ Ex Order 26.4 that she called the Police who took the report of the missing NJ Ex Order 26.4(b) over the phone and she notified the Department of Health.

The surveyor asked the ED if she reported the theft of NJ Ex Order 26.4(b) to New Jersey Department of Law and Public Safety, Division of Consumer Affairs, Enforcement Bureau of Professional Boards, she replied, "No."

The ED further stated that she informed the

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A1013	Continued From page 11 regional team and was told to report the theft of [NJ Ex Order 26.4(b)] to the DOH and to the police. The ED also stated that she was unaware that the theft should have reported the theft to the Drug Enforcement Agency (DEA). Later that day at 3:00 p.m., the ED gave the surveyor a copy of a document titled, "Report of Theft or Loss of Controlled Substances" dated, [NJ Ex Order 26.4] and stated that she reported the theft to the DEA. The surveyor reviewed the facility's policy titled, "Narcotic Policy, Count & Storage" which revealed, "...Any diversion of a controlled substance will [be] reported to the proper authorities." The facility failed to notify the DEA of the missing narcotics until 6 days after the incident.	A1013		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
04A005 Y1	A. Building B. Wing Y2	11/12/2020 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 A0407	Correction	ID Prefix A1011	Correction
Reg. # 8:36-3.4(a)(1)	Completed	Reg. # 8:36-4.1(a)(25)	Completed	Reg. # 8:36-11.7(k)	Completed
LSC	10/09/2020	LSC	10/09/2020	LSC	10/09/2020
ID Prefix A1013	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:36-11.7(l)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	10/05/2020	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	
10/5/2020	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO