

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>11/07/2025</b>
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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>
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(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: COMPLAINT #: NJ00180693, NJ00181736, NJ00182418, NJ00183440, NJ00186216, NJ00186382, NJ00187092, NJ00187708, NJ00187720, NJ00188367, NJ00188437, NJ00188442, NJ00188475, NJ00188531, NJ00188566, NJ00188658, NJ00188725, NJ00188727, NJ00188964, NJ00189078, NJ00189087</p> <p>CENSUS: 109 SAMPLE SIZE: 27</p> <p>TYPE OF SURVEY: Standard Survey of 100 residential units</p> <p>The facility is not in substantial compliance with all 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.</p> <p>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.</p>	A 000		
A 310	<p>8:36-3.4(a)(1) Administration</p> <p>(a) The administrator or designee shall be responsible for, but not limited to, the following:</p> <p>1. Ensuring the development, implementation, and enforcement of all policies and procedures, including resident rights;</p>	A 310		

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

TITLE

(X6) DATE

01/02/26

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A 310	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility document and policy review, the facility failed to ensure facility policies were followed for investigations of incidents, accidents, <sup>NJ Exec Or</sup> [REDACTED], and <sup>NJ Exec Order 26</sup> [REDACTED] and <sup>NJ Exec Order 26</sup> [REDACTED] for 6 (Residents #2, #6, #7, #8, #9, and #12) of 12 residents reviewed for <sup>NJ Exec Order 26.4b1</sup> [REDACTED] incidents. Additionally, the facility failed to ensure policies were in place regarding <sup>NJ Exec Order 26.4b1</sup> [REDACTED] provider orders and failed to ensure an order was implemented and services arranged when a Nurse Practitioner (NP) ordered a <sup>NJ Exec Order 26.4b1</sup> [REDACTED] study for 1 (Resident #20) of 3 residents reviewed for timely appointments.</p> <p>Findings included:</p> <p>An undated facility policy titled, "Incident and Accident Reporting Policy for Assisted Living Facility," revealed, "3. Incident and Accident Investigation: - Investigation Process: - Once an incident or accident is reported, a designated staff member (e.g. [exempli gratia, for example], supervisor or administrator) must investigate the cause and circumstances surrounding the event. - The investigation should involve gathering</p>	A 310		
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A 310	<p>Continued From page 2</p> <p>statements from witnesses, reviewing relevant medical or care records, and identifying any environmental factors that contributed to the incident. - The investigation should identify whether the incident was preventable and any corrective or preventive actions that should be taken." The policy also revealed, "4. Documentation: - Incident Report Form: - All incidents and accidents must be documented in an incident report, including: - Date, time, and location of the event. - Individuals involved, including witnesses. - A description of the incident or accident, including the sequence of events leading to it. - Immediate actions taken, such as first aid or medical attention. - Any follow-up care of interventions required."</p> <p>An undated facility policy titled, "Assisted Living Resident Issue Investigation Policy," revealed, "The purpose of this policy is to establish a clear and standardized procedure for investigation resident issues, including complaints, falls, accidents, incidents of drug overdose, and any other concerns or grievances in the assisted living facility. The policy aims to ensure a thorough, fair, and impartial investigation process to resolve issues and uphold the safety, well-being, and rights of all residents." Section "Drug Overdose or Suspected Drug Use" revealed, "2. Investigation of Overdose/Drug Use: - A formal investigation will be initiated immediately after medical care has been administered and the situation is under control. - The investigation will determine: - The cause and nature of the drug overdose (whether accidental or intentional). - The possible involvement of controlled substances, including prescription medications, illegal drugs, or alcohol. - Whether the overdose or drug use was related to the behavior or negligence of staff members. - Any</p>	A 310		

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A 310	<p>Continued From page 3</p> <p>systemic issues in the facility's policies or practices related to medication administration or supervision. 3. Documentation: - All steps of the investigation will be carefully documented, including witness statements, medical records, and actions taken. - A report will be prepared outlining findings and actions to prevent future incidents. Pertinent docs [sic, documents] will be sent to DOH [Department of Health]." Section "Documentation and Reporting" indicated, "Investigation Records: All records related to complaints and investigations will be stored securely and in compliance with applicable privacy and confidentiality laws. - Final Report: A formal report will be written at the conclusion of every investigation. This report will outline the issue, the investigation process, findings, and any actions taken as a result."</p> <p>1. An "Admission Record" revealed the facility admitted Resident #2 on <b>NJ Exec Order 26.4b1</b>. According to the Admission Record, the resident had a medical history that included diagnosis of <b>NJ Exec Order 26.4b1</b>).</p> <p>Resident #2's "Service Plan Report" included a focus area, initiated <b>NJ Exec Order 26.4b1</b>, that indicated the resident admitted to <b>NJ Exec Order 26.4b1</b> prescribed by the primary health care provider (PCHP). Interventions indicated the resident was referred to <b>NJ Exec Order 26.4b1</b> services.</p> <p>Resident #2's "Service Plan Report" included a focus area, initiated <b>NJ Exec Order 26.4b1</b> for medication management. Interventions revealed <b>NJ Exec Order 26.4b1</b> of medications was revoked on <b>NJ Exec Order 26.4b1</b></p> <p>Resident #2's "Order Summary Report," dated <b>NJ Exec Order 26.4b1</b>, revealed <b>NJ Exec Order 26.4b1</b></p>	A 310		
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A 310	<p>Continued From page 4</p> <p><b>NJ Exec Order 26.4b1</b> ) was ordered every four hours as needed for <b>NJ Exec U</b> on <b>NJ Exec Order 26.4b1</b> and was discontinued on <b>NJ Exec Order 26.4b1</b>.</p> <p>Resident #2's <b>NJ Exec Order 26.4b1</b> Administration Checks" record indicated a <b>NJ Exec Order 26.4b1</b> administration check was completed on <b>NJ Exec Order 26.4b1</b>, and all medications were given to Resident #2, which included <b>NJ Ex</b> tablets. The <b>NJ Exec Order 26.4b1</b> Administration Checks record further indicated that a <b>NJ Exec Order 26.4b1</b> administration check was completed on <b>NJ Exec Order 26.4b1</b>, eight <b>NJ Exec Order 26.4b1</b> tablets were remaining, and all counts were correct. On <b>NJ Exec Order 26.4b1</b>, the form indicated the <b>NJ Exec Order 26.4b1</b> administration contract was revoked.</p> <p>A nurse's "Progress Note[s]," dated <b>NJ Exec Order 26.4b1</b> at 10:54 AM, revealed Resident #2's roommate called for assistance because Resident #2 was <b>NJ Exec Order 26.4b1</b>. The note revealed Resident #2 reported they <b>NJ Exec Order 26.4b1</b>. The note revealed the Director of Nursing (DON) was notified <b>NJ Exec Order 26.4b1</b> was found on Resident #2's side table, and the DON instructed Licensed Practical Nurse (LPN) #4 to remove medications from Resident #2's room. The note revealed when LPN #4 asked Resident #2 where the <b>NJ Exec Order 26.4b1</b> pills were, the resident reported they had <b>NJ Ex Order 26.4(b)(1)</b>.</p> <p>A DON's "Progress Note[s]," dated <b>NJ Exec Order 26.4b1</b> at 2:55 PM, revealed Resident #2 admitted to <b>NJ Exec Order</b> the <b>NJ Exec Order 26.4b1</b>.</p> <p>A facility "Reportable Event Record/Report," dated <b>NJ Exec Order 26.4b1</b>, revealed Resident #2 <b>NJ Ex</b> in their room. The report indicated that when</p>	A 310		

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A 310	<p>Continued From page 5</p> <p>nursing staff arrived, [NJ Exec Order 26.4b1] was found, Resident #2 was missing [NJ Exec Order 26.4b1] and Resident #2 reported the missing [NJ Exec Order 26.4b1] was sold. The report did not indicate how many [NJ Exec Order 26.4b1] pills were missing, if any other [NJ Exec Order 26.4b1] were involved, any witness statements, or other resident interviews.</p> <p>During an interview on 11/04/2025 at 9:36 AM, LPN #4 stated Resident #2's roommate had called the nurse's station and notified her that Resident #2 [NJ Exec Order 26.4b1]. LPN #4 stated when she entered Resident #2's room, she saw a [NJ Exec Order 26.4b1]. LPN #4 notified the DON of the [NJ Exec Order 26.4b1], and the DON instructed her to remove Resident #2's medications. LPN #4 stated she did not remember how many [NJ Exec Order 26.4b1] tablets she removed or were left as it was not documented, and there was not a [NJ Ex Order 26.4(b)] count sheet. LPN #4 stated that she knew there were not enough [NJ Exec Order 26.4b1] tablets left because the prescription indicated how often the medication should have been taken and how many were dispensed. LPN #4 stated there should have been an incident report but was unable to find it on the computer system.</p> <p>During an interview on 11/04/2025 at 9:59 AM, the DON stated she would not provide a copy of the incident report because they did not share that information.</p> <p>During an interview on 11/04/2025 at 11:10 AM, the DON stated LPN #4 notified her that Resident #2 had [NJ Exec Order 26.4b1] in the resident's room. The DON stated she went to Resident #2's room, [NJ Exec Order 26.4b1] pills were missing, and the resident would not state who the [NJ Exec Order 26.4b1] was [NJ Ex Order 26.4j].</p> <p>During an interview on 11/04/2025 at 12:44 PM,</p>	A 310		

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A 310	<p>Continued From page 6</p> <p>the Administrator (ADM) stated that he was not in the facility at the time of the incident. The ADM stated he did not have any information on the incident or who submitted the report. The ADM stated that he did not know where any documentation related to the incident was if it was not submitted with the report.</p> <p>During an interview on 11/07/2025 at 10:00 AM, the DON stated she was unsure how many [redacted] were missing, but it was an entire pack. The DON stated she did not document the amount of [redacted] pills Resident #2 had. The DON stated that to her knowledge other residents were not interviewed after the incident to determine if Resident #2 had offered to sell them [redacted]. The DON stated she did not participate in investigation.</p> <p>2. An "Admission Record" revealed the facility admitted Resident #12 on [redacted]. According to the Admission Record, the resident had a medical history that included diagnoses of [redacted].</p> <p>Resident #12's "Service Plan Report" included a focus area, initiated [redacted] that indicated [redacted], and interventions indicated Resident #12 was taken to the hospital after [redacted].</p> <p>Resident #12's "Resident Assessment," dated [redacted], indicated the resident had a [redacted] due to [redacted] use.</p> <p>A facility "Reportable Event Record/Report," dated [redacted], revealed Resident #12 [redacted] in their room on [redacted]. The report indicated another resident had gone to visit Resident #12 and then notified a nurse that</p>	A 310		

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A 310	<p>Continued From page 7</p> <p>Resident #12 appeared to be [redacted] NJ Exec Order 26.4b1 [redacted]. The report indicated the other resident returned to Resident #12's room where Resident #12 was [redacted] NJ Exec Order 26.4b1. The report indicated the other resident then called [redacted] NJ Exec Order 26.4b1 (emergency medical services, EMS), waited for EMS to arrive, and then notified the nursing staff EMS was there. The report included EMS administered [redacted] NJ Exec Order 26.4b1 [redacted]), and Resident #12 was transported to the hospital. The report did not indicate who the other resident was, what Resident #12 [redacted] NJ Exec Order 26.4b1 on, if the [redacted] NJ Exec Order 26.4b1 was intentional, or any witness statements.</p> <p>A Certified Medication Assistant's (CMA) progress note, dated [redacted] NJ Exec Order 26.4b1 at 5:28 PM, revealed Resident #12 was sent to the hospital after another resident contacted EMS.</p> <p>During an interview on 11/05/2025 at 10:45 AM, the Director of Nursing (DON) stated she was not in the building on the day of the incident with Resident #12. The DON stated she was on vacation and received an email from EMS indicating Resident #12 was showing signs of an [redacted] NJ Exec Order 26.4b1. The DON stated she did not investigate the incident and did not know who did.</p> <p>During an interview on 11/05/2025 at 1:00 PM, Licensed Practical Nurse (LPN) #4 stated she was working the day Resident #12 was sent to the hospital. LPN #4 stated a resident notified her that EMS had been called because Resident #12 was [redacted] NJ Exec Order 26.4b1. LPN #4 stated she did not remember who called EMS, and when she went upstairs to check the resident, EMS was already there. LPN #4 stated she was not able to assess Resident #12 because EMS was already there. LPN #4 also stated she was not aware of the</p>	A 310		

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A 310	<p>Continued From page 8</p> <p>resident [redacted] but Resident #12 did return with new orders for [redacted]</p> <p>During an interview on 11/05/2025 at 2:57 PM, the Former Administrator (ADM) stated he thought that he had investigated the incident, and the hospital told him that Resident #12 had [redacted]. The Former ADM stated he was unsure if there was any hospital paperwork. The Former ADM stated that he, the ADM, and the DON were responsible for completing the investigation.</p> <p>During a follow-up interview on 11/06/2025 at 9:52 AM, the DON stated the ADM was responsible for monitoring investigations of reportable events. The DON stated she did not participate in investigations and was only responsible to complete assessments. The DON stated the ADM should have had all of the paperwork and witness statements. The DON stated that she expected staff to follow facility policies.</p> <p>During an interview on 11/06/2025 at 11:58 AM, the ADM stated that witness statements were obtained, but he did not know where they were. The ADM stated the Former ADM was responsible for the investigation, and the ADM only typed up the findings of the investigation by the Former ADM. The ADM stated they did not have any medical records related to the incident or witness statements. The ADM stated the incident was an accident per the Former ADM's investigation. The ADM stated his expectation was that the person completing the investigation was responsible for handling everything, so things did not get lost. The ADM stated the Executive Director (ED) was responsible for monitoring investigations. The ADM stated that he expected</p>	A 310		

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A 310	<p>Continued From page 9</p> <p>staff to follow facility policies to the best of their ability.</p> <p>During an interview on 11/06/2025 at 12:33 PM, the ED stated that she did not work at the facility at the time of the incident and did not know who was responsible for completing the investigation. The ED stated that the hospital paperwork for Resident #12 must have been misfiled, and she had not found any witness statements for the incident. The ED stated her expectation was that the ED, ADM, and DON would complete investigations. The ED stated that she expected the investigations to consist of interviews with the effected parties, witnesses, and video footage to be reviewed. The ED stated that she was responsible for monitoring investigations. The ED stated that she expected staff to follow facility policies.</p> <p>3. An undated facility policy titled, "Assisted Living Resident Issue Investigation Policy," revealed, "2. Investigation of Abuse or Neglect: - A designated investigator, typically a member of the management team or an external third-party investigator, will interview all relevant parties (resident, staff, witnesses). - The investigator will review medical records, security footage, and any other available evidence. - The investigation will follow legal and regulatory requirements to ensure fairness and proper documentation. - DOH [Department of Health] will be updated with findings." The policy also revealed, "Final Report: A formal report will be written at the conclusion of every investigation. This report will outline the issue, the investigation process, findings, and any actions taken as a result."</p> <p>An "Admission Record," revealed the facility admitted Resident #6 on <small>NJ Exec Order 26.4b1</small>. According to the Admission Record, the resident had a</p>	A 310		

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A 310	<p>Continued From page 10</p> <p>medical history that included diagnoses of [redacted] and [redacted].</p> <p>Resident #6's "Service Plan Report," included a focus area for [redacted] revised [redacted]. Interventions included that Resident #6 was educated to [redacted] with two unnamed residents, to [redacted] where the two other residents resided, and education was provided on the proper response to [redacted] and to always get staff.</p> <p>An "Admission Record," revealed the facility admitted Resident #7 on [redacted]. According to the Admission Record, the resident had a medical history that included diagnoses of [redacted], and an [redacted].</p> <p>A "Reportable Event Record/Report," dated [redacted], revealed on [redacted] at 4:00 AM Resident #6 [redacted] Resident #7 in front of the facility.</p> <p>An undated "Investigative Summary," record revealed that Resident #7 was standing outside by the front entry "talking with people" when Resident #6 went out the front door and [redacted] Resident #7 in the [redacted] for [redacted]. The Investigative Summary revealed both residents were [redacted] both were told to [redacted], an emergency medical service was called to the facility, and the doctor was notified of the incident. The Investigative Summary indicated Resident #6 [redacted] the facility. No witness statements were included in the investigation.</p> <p>On 11/06/2025 at 12:02 PM, the Director of Nursing revealed that the Administrator (ADM)</p>	A 310		

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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>11/07/2025</b>
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NAME OF PROVIDER OR SUPPLIER  <b>BENTLEY COMPREHENSIVE CARE LLC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>7999 NORTH ROUTE 130 PENNSAUKEN, NJ 08110</b>
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A 310	<p>Continued From page 11</p> <p>completed investigations and gathered witness statements.</p> <p>On 11/06/2025 at 9:08 AM the ADM revealed the "Investigative Summary" was complete at the time he submitted the incident to the Department of Health.</p> <p>4. An undated facility policy titled, "Assisted Living Resident Issue Investigation Policy," revealed, "2. Investigation of Abuse or Neglect: A designated investigator, typically a member of management or an external third-party investigator will interview all relevant parties (resident, staff, witnesses)."</p> <p>An Admission Record revealed Resident #8 was admitted to the facility on [redacted NJ Exec Order 26.4b1]. According to the Admission Record, the resident had a medical history that included diagnoses of [redacted NJ Exec Order 26.4b1].</p> <p>An "Admission Record" revealed Resident #9 was admitted to the facility on [redacted NJ Exec Order 26.4b1] and discharged on [redacted NJ Exec Order 26.4b1]. According to the Admission Record, the resident had a medical history that included diagnoses of [redacted NJ Exec Order 26.4b1] with [redacted NJ Exec Order 26.4b1] not due to a substance or known [redacted NJ Exec Order 26.4b1], [redacted NJ Exec Order 26.4b1], and [redacted NJ Exec Order 26.4b1].</p> <p>A "Reportable Event Record/Report" dated [redacted NJ Exec Order 26.4b1] Resident #9 [redacted NJ Exec Order 26.4b1] Resident #8 with a [redacted NJ Exec Order 26.4b1]. The report indicated the residents were [redacted NJ Exec Order 26.4b1] Resident #9 was [redacted NJ Exec Order 26.4b1] an ambulance was called, and the doctor was notified. The report indicated on return to the facility Resident #9 was [redacted NJ Exec Order 26.4b1], and Resident #9 was given a [redacted NJ Exec Order 26.4b1].</p>	A 310		

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A 310	<p>Continued From page 12</p> <p><b>NJ Exec Order 26.4b</b> toward another resident. An undated "Investigative Summary" revealed both residents were interviewed. The investigation did not include any statements from staff, including descriptions of Resident #8's <b>NJ Exec Order</b>.</p> <p>A nurse's "Progress Note[s]," dated <b>NJ Exec Order 26.4b1</b> at 11:49, revealed Resident #8 returned from the emergency room with <b>NJ Exec Order 26.4b1</b> on the <b>NJ Exec</b>, and instructions for a follow-up visit.</p> <p>On 11/07/2025 at 9:16 AM, the Administrator (ADM) stated the Former ADM did the majority of the investigation and spoke to staff. The ADM stated there were no written staff statements.</p> <p>On 11/07/2025 at 2:13 PM, the Director of Nursing stated the ADM was responsible for investigating <b>NJ Exec Order 26.4b1</b> incidents and getting witness statements.</p> <p>5. An undated facility policy titled "Health Care Services" indicated, "Policy - Our facility shall ensure that the resident receives health care services under the direction of a registered professional nurse, in accordance with the health care plan." The policy also indicated, "4. The registered nurse will follow-up with medical referrals as appropriate."</p> <p>On 11/07/2025 at 4:07 PM, the Administrator (ADM) stated the facility had no polices regarding stat provider orders.</p> <p>An "Admission Record" revealed the facility admitted Resident #20 on <b>NJ Exec Order 26.4b1</b>. According to the Admission Record, Resident #20 had a medical history that included diagnosis of an <b>NJ Exec Order 26.4b1</b>.</p>	A 310		

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A 310	<p>Continued From page 13</p> <p>A [NJ Ex Order 26.4(b)(1)] Standard Level of Care and Service Plan (with Scoring)," record, dated [NJ Exec Order 26.4b1], indicated Resident #20 was [NJ Exec Order 26.4b1] and capable of [NJ Exec Order 26.4b1].</p> <p>An "Order Summary Report," with active physician's orders as of [NJ Exec Order 26.4b1], revealed Resident #20 received [NJ Exec Order 26.4b1] [redacted] daily, started [NJ Exec Order 26.4b1].</p> <p>A late entry NP's "Progress Note[s]," dated [NJ Exec Order 26.4b1] at 2:56 PM, revealed Resident #20 experienced an [NJ Exec Order 26.4b1] of [NJ Exec Order 26.4b1]. The note indicated that Resident #20 had reported to the NP a sudden onset of [NJ Exec Order 26.4b1] and noticeable [NJ Exec Order 26.4b1] in the [redacted] over the previous 48 hours. The note indicated Resident #20 rated the [redacted] with [redacted] being the [redacted] possible. The note indicated Resident #20 described the [redacted] as [redacted] and [redacted] that [redacted] when [redacted] or [redacted]. The note indicated the NP's plan for, [NJ Exec Order 26.4b1] [redacted].</p> <p>An NP "Prescription," dated [NJ Exec Order 26.4b1] revealed [redacted] "to Resident #20's [redacted] [NJ Exec Order 26.4b1].</p> <p>Resident #20's Progress Note[s], for the timeframe from [NJ Exec Order 26.4b1] through [NJ Exec Order 26.4b1], included no documentation that the stat [redacted] study had been completed as ordered.</p> <p>A concurrent observation and interview was held with Resident #20 on [NJ Exec Order 26.4b1] at 8:51 AM. Resident #20 stated the NP had ordered a [redacted] study of their [redacted] to rule out [redacted].</p>	A 310		

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A 310	<p>Continued From page 14</p> <p>NJ Exec Order 26.4b1 An observation revealed Resident #20's NJ Exec Order 26.4b1 was noticeably NJ Exec Order 26.4b1 and appeared NJ Exec Order 26.4b1 than the NJ Exec Order 26.4b1 Resident #20 stated the NJ Exec Order 26.4b1.</p> <p>Licensed Practical Nurse (LPN) #4 was interviewed on 11/07/2025 at 9:06 AM. LPN #4 stated she had entered the order requisition for Resident #20's NJ Exec Order 26.4b1 that morning NJ Exec Order 26.4b1. LPN #4 stated she had not been working on NJ Exec Order 26.4b1 when the order was received, and the assigned nurse for Resident #20 that day should have entered the order.</p> <p>The Director of Nursing (DON) was interviewed on 11/07/2025 at 9:45 AM and stated that if the NP or the physician ordered a test to be completed NJ Exec Order 26.4b1 that meant the test needed to be completed within three to four hours. The DON stated one of the nurses had called earlier in the week to schedule Resident #20's NJ Exec Order 26.4b1, but she was not sure when the call had occurred, or which nurse had called to schedule the test. The DON stated she was unable to remember if she had placed the order requisition for the NJ Exec Order 26.4b1 into the electronic system or if someone else had placed the requisition. The DON confirmed the NJ Exec Order 26.4b1 order requisition should have been entered on Monday, NJ Exec Order 26.4b1 when the NP gave the order.</p> <p>A telephone interview was held with the NP on 11/07/2025 at 11:30 AM. The NP stated he had seen Resident #20 on NJ Exec Order 26.4b1 and found the resident to have NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 in the NJ Exec Order 26.4b1 but the resident was still NJ Exec Order 26.4b1 and a NJ Exec Order 26.4b1 was present in the NJ Exec Order 26.4b1. The NP stated he ordered a stat NJ Exec Order 26.4b1 to rule out a NJ Exec Order 26.4b1 in the resident's NJ Exec Order 26.4b1. The NP stated NJ Exec Order 26.4b1 meant to</p>	A 310		
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A 310	<p>Continued From page 15</p> <p>complete the [redacted] quickly. The NP stated he saw Resident #20 again on [redacted] and told the staff again on that day that the [redacted] was needed. The NP stated he also spoke to someone on [redacted] about the need for the [redacted] and then received a call later that same day from a nurse who told him she had been home before she became aware of the order so she would order it first thing on [redacted]. The NP stated because of the facility's location it was hard to get companies in to do testing, and that was the primary reason he wrote for the study to be done [redacted]. The NP stated he expected the testing to be done within one to two days after the order and would have liked to have been notified when the [redacted] had not been done.</p> <p>The Administrator (ADM) was interviewed on 11/07/2025 at 12:42 PM. The ADM stated he expected the nursing staff to enter the order when it was received and the test to be done as soon as possible or within 24 hours.</p>	A 310		
A 389	<p>8:36-4.1(a)(16) Resident Rights</p> <p>(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:</p> <p>16. The right to be free from physical and mental abuse and/or neglect;</p>	A 389		

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A 389	<p>Continued From page 16</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility document and policy review, the facility failed to prevent exploitation when staff purchased a resident's <b>NJ Exec Order 26.4b1</b> from 1 (Resident #1) of 18 sampled residents reviewed for <b>NJ Exec Order 26.4b1</b>.</p> <p>Findings included:</p> <p>The facility's undated policy titled, "Abuse and Neglect," revealed, "Purpose: To prevent, identify, and respond appropriately to any form of abuse, neglect, or exploitation of residents at [facility name], to ensure a safe, respectful, and dignified environment for all individuals under our care." The policy further indicated, "Exploitation: The illegal or improper use of a resident's resources for another's profit or advantage."</p> <p>An "Admission Record" revealed the facility admitted Resident #1 on <b>NJ Exec Order 26.4b1</b>. According to the Admission Record, the resident had a medical history that included diagnoses of <b>NJ Exec O</b></p> <p>Resident #1's "Service Plan Report" included a focus area revised <b>NJ Exec Order 26.4b1</b> indicated the resident needed assistance with <b>NJ Exec Order 26.4b</b> management. Interventions directed staff to assist the resident in paying <b>NJ Exec O</b> and <b>NJ Exec Order 2</b></p> <p>A "Reportable Event Record/Report," dated <b>NJ Exec Order 26.4b1</b> revealed Resident #1 reported they offered their <b>NJ Exec Order 26.4b1</b> to CMA #6 and other employees. The Reportable Event Record/Report indicated Resident #1 claimed that</p>	A 389		

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A 389	<p>Continued From page 17</p> <p>CMA #6 assisted the resident [redacted] and then used the [redacted]. Per the Reportable Event/Report, Resident #1 indicated they had [redacted] and that CMA #6 used all [redacted] the resident most of what she owed the resident but still owed them \$ [redacted] and [redacted] to [redacted] the resident.</p> <p>A typed statement dated [redacted], signed by Resident #1, revealed the resident [redacted] to CMA #6 for [redacted]. Per the typed statement, Resident #1 indicated there was [redacted] and the resident told CMA #6 they could have the [redacted] typed statement further indicated that CMA #6 had [redacted] the Resident #1 [redacted] but still owed the resident [redacted]. Per the statement, CMA #6 said they did not owe Resident #1 any [redacted] and [redacted] to [redacted] the resident back, therefore the resident informed the Administrator (ADM).</p> <p>A handwritten statement dated 06/21/2024, signed by CMA #6 revealed that Resident #1 agreed to [redacted] worth of the resident's [redacted] to CMA #6 for [redacted] on [redacted]. CMA #6 stated that she [redacted] Resident #1 the agreed amount.</p> <p>During an interview on 11/04/2025 at 6:00 PM, CMA #6 stated she had never [redacted] or anything from a resident prior to that incident. CMA #6 stated she did not know she was [redacted] from a resident until after [redacted] from Resident #1. CMA #6 did not remember how much she [redacted] or how many [redacted] she received. CMA #6 stated Resident #1 told her they (the resident) would accept whatever she had. CMA #6 stated she</p>	A 389		
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
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A 389	<p>Continued From page 18</p> <p>NJ Exec Order 26.4b1 from her family member and NJ Exec Order 26.4b1. CMA #6 thought it was around NJ Exec Order 26.4b1 that she NJ Exec Order 26.4b1 the resident. CMA #6 stated she then took the NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 the NJ Exec Order 26.4b1. CMA #6 stated the next day Resident #1 was asked CMA #6's coworkers to call her and tell her she needed to give the NJ Exec Order 26.4b1. CMA #6 stated she returned the NJ Exec Order 26.4b1 and was called in to work because the resident reported her to the Administrator (ADM), who was no longer working at the facility. CMA #6 stated she was NJ Exec Order 26.4b1 for almost a week and received education that she could NJ Exec Order 26.4b1 anything from residents.</p> <p>During an interview on 11/05/2025 at 10:45 AM, the Director of Nursing (DON) stated that she became aware of the incident when the ADM notified her. The DON stated she obtained a statement from CMA #6 and sent her home while they conducted an investigation. The DON said she educated CMA #6 concerning exploitation and that staff were not allowed to take anything from residents. The DON stated her expectation was that staff did not take anything from residents.</p> <p>During an interview on 11/05/2025 at 2:27 PM, the ADM stated he was not working at the facility at the time of the incident and was not familiar with the incident. The ADM stated he expected staff not to NJ Exec Order 26.4b1 from residents, and the Executive Director (ED) was responsible for investigating NJ Exec Order 26.4b1.</p> <p>During an interview on 11/06/2025 at 12:49 PM, the ED stated that she did not work at the facility at the time of the incident and was not familiar with the incident. The ED stated that she expected staff not to engage in activities of NJ Exec Order 26.4b1.</p>	A 389		
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A 389	Continued From page 19 or 	A 389		
A 585	<p>8:36-5.11(a)(6) General Requirements</p> <p>(a) The facility shall conspicuously post a notice that the following information is available in the facility during normal business hours, to residents and the public:</p> <p style="padding-left: 40px;">6. The toll-free hot line number of the Department; telephone numbers of county agencies and of the State of New Jersey Office of the Ombudsman;</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy review, the facility failed to ensure the contact information for the New Jersey Department of Health was available for residents and visitors.</p> <p>Findings included:</p> <p>An undated facility policy titled, "[Facility Name] Policy and Procedures," revealed, "The following information is available to residents and the public during normal business hours (Monday - Friday from 9:00 AM - 4:30 PM). If you wish to contact the Department of Health and Senior Services toll-free hotline, the telephone number is: 1-800-367-6543."</p> <p>During a tour of the facility and an interview with the Executive Director and Administrator on 11/06/2025 at 9:25 AM, revealed they were unable to locate the number for the Department</p>	A 585		

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A 585	Continued From page 20 of Health.	A 585		
A 709	<p>8:36-7.2(d)(1-18) Resident Assessments and Care Plans</p> <p>(d) Each health care assessment by the registered professional nurse shall include, at a minimum, evaluation of the following:</p> <ol style="list-style-type: none"> <li>1. Need for assistance with "activities of daily living";</li> <li>2. Cognitive patterns;</li> <li>3. Communication/hearing patterns;</li> <li>4. Vision patterns;</li> <li>5. Physical functioning and structural problems;</li> <li>6. Continence;</li> <li>7. Psychosocial well-being;</li> <li>8. Mood and behavior problems;</li> <li>9. Activity pursuit patterns;</li> <li>10. Disease diagnoses;</li> <li>11. Health conditions and preventive health measures, including, but not limited to, pain, falls, and lifestyle;</li> <li>12. Oral/nutritional status;</li> <li>13. Oral/dental status;</li> </ol>	A 709		

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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>11/07/2025</b>
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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>
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A 709	<p>Continued From page 21</p> <p>14. Skin conditions;</p> <p>15. Medication use;</p> <p>16. Special treatment and procedures;</p> <p>17. Restraint use;</p> <p>18. Outside service utilization.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, the facility failed to ensure a <b>NJ Exec</b> risk assessment was conducted for 3 (Residents #2, #25, and #30) of 4 residents reviewed for <b>NJ Exec</b>.</p> <p>Findings included:</p> <p>An undated facility policy titled, "Falls," revealed, "1. Upon admission, all residents shall be screened for history of falls and the risk for potential falls."</p> <p>1. An "Admission Record" revealed the facility admitted Resident #2 on <b>NJ Exec Order 26.4b1</b>. According to the Admission Record, the resident had a medical history that included diagnosis of <b>NJ Exec Order 26.4b1</b> ) and encounter for other <b>NJ Exec Order 26.4b1</b>.</p> <p>Resident #2's "Medical Evaluation (Resident)," dated <b>NJ Exec Order 26.4b1</b> revealed the resident's <b>NJ Exec Order 26.4b1</b> was a <b>NJ Exec Order 26.4b1</b> and a <b>NJ Exec Order 26.4b1</b>. Per the evaluation, the resident had <b>NJ Exec Order 26.4b1</b> to <b>NJ Exec Order 26.4b1</b> the <b>NJ Exec Order 26.4b1</b> on <b>NJ Exec Order 26.4b1</b>.</p>	A 709		

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A 709	<p>Continued From page 22</p> <p>Resident #2's medical record revealed no documented evidence that the facility screened the resident for [redacted] upon admission to the facility.</p> <p>Resident #2's "Service Plan Report" dated [redacted] revealed the resident was independent with [redacted]. The Service Plan Report did not address whether the resident was at risk for [redacted] or had a history of [redacted].</p> <p>Resident #2's "Progress Notes," revealed Licensed Practical Nurse (LPN) #4 entered an "Incident Note," dated [redacted] at 10:54 AM that indicated Resident #2's roommate called for assistance because Resident #2 [redacted]. According to the notes, Resident #2 reported that [redacted].</p> <p>2. An "Admission Record" revealed the facility admitted Resident #25 on [redacted]. According to the Admission Record, the resident had a medical history that included diagnoses of [redacted].</p> <p>Resident #25's "Medical Evaluation (Resident)," dated [redacted] revealed the resident was [redacted] and [redacted] but [redacted]."</p> <p>Resident #25's medical record revealed no documented evidence that the facility screened the resident for [redacted] upon admission to the facility.</p> <p>Resident #25's "Incident Note" effective [redacted] at 9:40 AM revealed, the resident [redacted] and [redacted] to the [redacted].</p>	A 709		
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A 709	<p>Continued From page 23</p> <p>and [redacted] and was transferred to the hospital.</p> <p>3. An "Admission Record" revealed the facility admitted Resident #30 on [redacted]. According to the Admission Record, the resident had a medical history that included diagnoses of [redacted]</p> <p>Resident #30's medical record revealed no documented evidence that the facility screened the resident for [redacted] upon admission to the facility.</p> <p>Resident #30's "Progress Notes," dated [redacted] at 3:27 PM, revealed a nurse practitioner documented that the resident had an [redacted] after [redacted] and [redacted]</p> <p>During an interview on 11/07/2025 at 10:00 AM, the Director of Nursing (DON) stated the "Medical Evaluation" was the resident's admission assessment. She stated residents were not screened upon admission to determine if they were a [redacted]. According to the DON, [redacted] assessments were not completed in assisted living facilities. The DON stated she determined if a resident was at risk of [redacted] by doing her natural assessment, which meant she looked at the residents.</p> <p>During an interview on 11/07/2025 at 10:41 AM, the Administrator (ADM) stated he expected residents to have a comprehensive upon admission to the facility, which included determining whether the resident was a [redacted] risk. The ADM also stated that he expected residents to be reassessed for [redacted] risks after a resident had [redacted]. The ADM stated that the DON was</p>	A 709		

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A 709	Continued From page 24 responsible for monitoring to ensure those assessments were completed.	A 709		
A 959	<p>8:36-11.5(d) Pharmaceutical Services</p> <p>(d) Medication prescribed for one resident shall not be administered to another resident. Borrowing shall not occur.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure medication for administration was not borrowed from another resident for 1 resident (Resident #30) of 4 residents reviewed during the medication pass.</p> <p>Findings included:</p> <p>An "Admission Record" revealed the facility admitted Resident #30 on [redacted] According to the Admission Record, the resident had a medical history that included diagnoses of [redacted] and [redacted].</p> <p>A Brief Interview for Mental Status (BIMS) assessment, effective [redacted], indicated Resident #30 had [redacted].</p> <p>Resident #30's "Senior Living Standard Level of Care and Service Plan (with Scoring)," dated [redacted], indicated the resident reported [redacted] exhibited signs of [redacted] and required assistance with [redacted] management.</p> <p>Resident #30's "Order Summary Report," with</p>	A 959		

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A 959	<p>Continued From page 25</p> <p>active orders as of [redacted], included a physician's order, dated [redacted], for [redacted] NJ Exec Order 26.4b1 one tablet to be given every four hours as needed for [redacted] NJ Exec Ord. The Order Summary Report included a physician's order, started [redacted] NJ Exec Order 26.4b1, for [redacted] NJ Exec Order 26.4b1 to be taken every eight hours as needed for [redacted] NJ Exec Ord.</p> <p>An observation was made beginning on [redacted] NJ Exec Order 26.4b1 at 8:47 AM of Licensed Practical Nurse (LPN) #4 preparing medications for Resident #30. The observation revealed on [redacted] NJ Exec Order 26.4b1 at 8:54 AM, Resident #30 asked for [redacted] NJ Exec Order 26.4b1 and LPN #4 responded that no [redacted] NJ Exec Order 26.4b1 was available. The observation revealed the Administrator (ADM), who was also an LPN and was passing medications at that time, went into another room and returned with two white tablets in a clear medication cup. The observation revealed the ADM added the two white tablets to another cup that had been prepared with medications for Resident #30 by LPN #4. A concurrent interview revealed LPN #4 stated she had not seen the medication card the two white tablets had been taken from, but she recognized the tablets as [redacted] NJ Exec Order 26.4b1 because she knew what [redacted] NJ Exec Order 26.4b1 looked like. The concurrent interview revealed LPN #4 stated she should not have taken the medication from the ADM to give to Resident #30 since she did not know what medication the ADM had placed in the cup, and she had been taught in nursing school not to give medication she had not prepared. The observation revealed LPN #4 removed the white tablets from the medication cup. The observation revealed, when asked to see the specific card from where the white tablets had been retrieved, the ADM brought a</p>	A 959		

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A 959	<p>Continued From page 26</p> <p>medication card containing acetaminophen tablets with another resident's name at the top of the card.</p> <p>The ADM was interviewed on 11/06/2025 at 12:41 PM. The ADM stated removing <b>NJ Exec Order 26.4b1</b> from another resident's medication card and giving the medication to LPN #4 to administer to Resident #30 <b>NJ Exec Order 28.4b1</b>. The ADM stated he had been trying to help LPN #4 and had learned from his mistake.</p> <p>The Executive Director (ED) was interviewed on 11/06/2025 at 1:02 PM. The ED stated the ADM should not have used medication belonging to another resident.</p>	A 959		
A 985	<p>8:36-11.7(b)(1) Pharmaceutical Services</p> <p>(b) All medications shall be kept in their original containers and shall be properly labeled and identified.</p> <p>1. The label of each resident's prescription medication container shall be permanently affixed and contain the resident's full name, prescriber's name, prescription number, name and strength of medication, lot number, quantity, date of issue, expiration date, manufacturer's name if generic, directions for use, and cautionary and/or accessory labels. Required information appearing on individually packaged medications or within an alternate medication delivery system need not be repeated on the label.</p>	A 985		

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A 985	<p>Continued From page 27</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure insulin pens were labeled with the resident's full name, prescriber name, prescription number, name and strength of medication, lot number, date of issue, expiration date, and direction for use for 41 of 41 insulin pens observed in 1 of 1 medication storage refrigerators. This had the potential to affect 17 of 17 residents identified by the facility as having orders for insulin.</p> <p>Findings included:</p> <p>A handwritten document provided by the facility revealed they had 17 residents with orders for insulin.</p> <p>An observation of the medication room on 11/06/2025 at 12:18 PM with Licensed Practical Nurse (LPN) #4 revealed four plastic boxes of insulin pens in the door of the refrigerator with only the manufacturer's label on each pen. The boxes contained the following insulin pens: eight <b>NJ Exec Order 26.4b1</b> [REDACTED] for a total of 41 insulin pens. LPN #4 verified the count of insulin pens that contained only the manufacturer's label and no identifying resident information.</p> <p>An interview with LPN #4 on 11/06/2025 at 12:34 PM revealed she was not aware there were insulin pens in the refrigerator labeled only the manufacturer's label and did not know who, if anyone, inventoried the insulin pens. She stated they should not use insulin pens without the</p>	A 985		
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A 985	<p>Continued From page 28</p> <p>pharmacy label; they should have been sent back to the pharmacy for labels.</p> <p>An interview with the Pharmacist on 11/07/2025 at 11:02 AM revealed the insulin pen labels should include the five rights of medication administration: the resident, medication, dose, route, and time. She stated it was not a written policy but was their internal policy and practice for labeling medications to use the five rights.</p> <p>An interview with the Pharmacy Consultant on 11/07/2025 at 11:36 AM revealed he visited the facility every three months and did not recall seeing any insulin pens that contained only the manufacturer's label in the refrigerator.</p> <p>An interview with the Director of Nursing (DON) on 11/06/2025 at 1:32 PM revealed the facility had no house stock supply for insulin or other medications.</p> <p>During a follow-up interview on 11/07/2025 at 2:16 PM, the DON stated no one inventoried the medication other than the pharmacy consultant and no staff had reported to her the insulin pens only had a manufacturer label so she was unaware.</p> <p>An interview with the Executive Director on 11/07/2025 at 2:23 PM stated she was unsure who monitored the medications in the refrigerator and that no one had reported to her that the insulin pens were not labeled properly.</p>	A 985		
A1051	<p>8:36-15.2 Resident Records</p> <p>The records required by this subchapter shall be maintained for all residents and shall be kept</p>	A1051		

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A1051	<p>Continued From page 29</p> <p>available on the premises for review at any time by representatives of the Department.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, interview, and facility policy review, the facility failed to maintain a complete health record for 1 (Resident #26) of 7 residents reviewed for medications.</p> <p>Findings included:</p> <p>An undated facility policy titled, "Resident Record," revealed, "1. A record shall be maintained for all residents residing in the assisted living residence. 2. The resident record shall contain information regarding the individual resident. Each record shall include at least the following:" and included, "d. All assessments and treatments by the health and service providers." The policy also revealed, "5. All records shall be kept available on the premises for review at any time by representatives of the Department of Health."</p> <p>An "Admission Record" revealed the facility admitted Resident #26 on <b>NJ Exec Order 26.4b1</b>. According to the Admission Record, the resident had a medical history that included diagnoses of <b>NJ Exec Order 26.4b1</b> and <b>NJ Exec Order 26.4b1</b>. The Admission Record also indicated that the resident was discharged on <b>NJ Exec Order 26.4b1</b>.</p> <p>Resident #26's closed record revealed Medication Administration Records (MARs) were available for <b>NJ Exec Order 26.4b1</b> and <b>NJ Exec Order 26.4b1</b>; however, there were no MARs available for <b>NJ Exec Order 26.4b1</b>.</p>	A1051		

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A1051	<p>Continued From page 30</p> <p>During an interview on 11/06/2025 at 1:32 PM, the Director of Nursing stated Resident #26 should have had a MAR for <b>NJ Exec Order 26.4b1</b> [REDACTED]. She revealed that the lack of documentation was an error in her department.</p> <p>On 11/07/2025 at 9:45 AM, the Administrator stated Resident #26 should have had MARs completed for <b>NJ Exec Order 26.4b1</b> [REDACTED] until the date the resident was discharged.</p> <p>On 11/07/2025 at 2:45 PM, the Executive Director stated that a resident should have had a MAR even if the resident <b>NJ Exec Order 26.4b1</b> [REDACTED] their medication.</p>	A1051		

POC# 2 Received  
1/23/26  
Acceptable



**Bentley Comprehensive Care, LLC**  
**NJ# 04A005**  
**7999 North Route 130**  
**Pennsauken, New Jersey 08110**

**Standard and Complaint Survey Dated 11/07/2025**

**ST- A 310 8:36-3.4(a)(1) Administrator's Responsibilities (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;**

**1 Immediate Correction of Deficiency**

On 2/12/25 Resident #2's **NJ Exec Order 26.4b1** of medications was **NJ Exec Order 26.4b1** Resident #2 currently resides in the community. The community manages his/her medication. There have not been any further incidents regarding Resident #2 since the incident in **NJ Exec Order 26.4b1** Resident #12 no longer resides at this community. He/she was discharged on **NJ Exec Order 26.4b1** Resident #6 no longer resides in the community. He/she permanently left the facility. Resident #7 no longer resides in the community. He/she was **NJ Exec Order 26.4b1** discharged on **NJ Exec Order 26.4b1** Resident #9 was served a **NJ Exec Order 26.4b1** notice to **NJ Exec Order 26.4b1** toward another resident. He/she no longer resides in the community discharged on **NJ Exec Order 26.4b1** Resident #8 currently resides in the community there has been no additional incidents involving Resident #8. Resident #20 was sent to the hospital for further evaluation. Resident #20 returned from the hospital on **NJ Exec Order 26.4b1** Resident #20 currently resides in the community.

The "Incident and Accident Reporting Policy for Assisted Living Facility" and the "Assisted Living Resident Issue Investigation" policies were immediately reviewed and revised by the administrative team. Resulting in a new policy entitled "Incident, Investigation, and Reporting Policy and Procedure" All staff was educated by the Executive Director on the new policy during in-person all staff town hall meeting held on 11/13/2025. Any staff that was unable to attend the town hall was educated on the new policy individually by their department director or designee.

Director of Nursing (DON)/ Assistant Director of Nursing (ADON) must be made aware if any stat orders are received. All nursing staff was educated by the DON on 11/7/25 that stat orders are not accepted in this community. Therefore, in the event a stat order is received, the ordering physician must be contacted. If the orders are urgent the resident will be sent to the hospital to ensure that they receive proper medical attention.



The community will create a policy and procedure regarding stat provider orders. All staff will be educated on the stat provider order policy immediately upon completion.

**2. Residents with the potential to be affected**

All residents at the facility have the potential to be affected by this deficient practice.

**3. Measures put in place to ensure the deficient practice will not re-occur**

The facility's Incident and Accident Reporting Policy for Assisted Living Facility and the Assisted Living Resident Issue Investigation revised. They were merged into one policy entitled Incident, Investigation, and Reporting Policy and Procedure. The new policy specifies that staff must ensure safety, provide necessary medical care, and report the incident to their Department Director, the Administrator, or the Manager on Duty. Internal reporting will include a complete incident summary detailing time, individuals involved, actions taken, and witnesses. The Administrator must ensure policy implementation, timely reporting, corrective action oversight, coordinate and complete investigations and investigative summary, and maintain documentation. All staff was educated by Executive Director on the new policy during in-person all staff town hall meeting held on 11/13/2025. Any staff that was unable to attend the town hall was educated on the new policy individually by their department director or designee.

Director of Nursing (DON)/ Assistant Director of Nursing (ADON) must be made aware of all stat orders. All nursing staff was educated by the DON on 11/7/25 that in the event a stat order is received, the ordering physician must be contacted. If the orders are urgent the resident will be sent to the hospital to ensure that they receive proper medical attention.

The community will create a policy and procedure regarding stat provider orders. All nursing staff will be educated on the stat provider order policy immediately upon completion by the Director of Nursing/ Designee.

**4. How will the facility monitor that the deficient practice is being corrected and will not reoccur? (Including frequency of monitoring, person responsible, and a completion date)**

During daily morning meeting all incidents and/ or accidents are reviewed and discussed among department head team and administrator. Executive Director (ED) will conduct weekly audit for three months beginning January 2026 of all incidents to ensure they are being properly reported by staff, the internal reporting is completed according to policy, and the investigation is complete, including witness statements. All incidents will be reviewed quarterly by Administrator/ Designee. The Incident, Investigation, and Reporting Policy and Procedure will be reviewed annually by Administrator/ Designee. All staff will receive training on incident recognition, reporting, and investigation procedures annually and upon hire.



The Director of Nursing (DON) or Designee will review orders daily for one month beginning January 2026 to ensure that all stat orders are properly addressed.

*Accepted*

**Completion date:** 1/12/2026

**ST- A 389 8:36-4.1(a)(16) Residents Rights (a) Each assisted living provider will post and distribute a statement of assisted living residences, comprehensive personal care home, and assisted living programs. Each resident is entitled to the following rights:**

**16. The right to be free from physical and mental abuse and/or neglect;**

**1. Immediate Correction of Deficiency**

In <sup>NJ Exec Order 26.4b1</sup> CMA #6 was <sup>NJ Exec Order 26.4b1</sup> immediately pending investigation of a resident <sup>NJ Exec Order 26.4b1</sup> was founded. CMA #6 was returned from <sup>NJ Exec Order 26.4b1</sup> and educated that she could not <sup>NJ Exec Order 26.4b1</sup> anything from residents by the DON. CMA #6 was also re-educated on the <sup>NJ Exec Order 26.4b1</sup> policy by the DON. Resident #1 no longer resides in the community he/she was discharged as of <sup>NJ Exec Order 26.4b1</sup>

**2. Residents with the potential to be affected**

All residents have the potential to be affected by this deficient practice.

**3. Measures put in place to ensure the deficient practice will not re-occur**

All staff was educated on the Abuse and Neglect policy by the Executive Director (ED) during an in-person all staff meeting on 10/9/2025. Any staff that was unable to attend the meeting was educated on the new policy individually by their department director or designee. All staff training emphasized the definitions of abuse, neglect, and exploitation. Exploitation is defined as the illegal or improper use of a resident's resources for another's profit or advantage. The training also focused on how to recognize, report, and prevent exploitation.

**4. How will the facility monitor that the deficient practice is being corrected and will not reoccur? (Including frequency of monitoring, person responsible, and a completion date**

During daily morning meeting all incidents and/ or accidents are reviewed and discussed among department head team and administrator. Executive Director (ED) will conduct weekly audit for three months beginning February 2026 of all incidents to ensure any allegations of exploitation are being properly reported and addressed. All incidents will be reviewed quarterly by Administrator/ Designee. The Abuse and Neglect Policy will be reviewed annually by Administrator/ Designee. All staff will receive training on abuse, neglect and exploitation



annually and upon hire. All allegations of abuse, neglect, and exploitation will be reviewed quarterly during QAPI meetings.

**Completion date:** 1/12/2026

**ST- A 585 8:36-5.11(a)(6) General Requirements (a) The facility shall conspicuously post a notice that the following information is available in the facility during normal business hours, to residents and the public:**

**6. The toll-free number of the Department; telephone numbers of county agencies and of the State of New Jersey Office of the Ombudsman;**

**1. Immediate Correction of Deficiency**

A posting was immediately placed behind the front desk including the toll-free numbers of county agencies and of the State of New Jersey Office of the Ombudsman. The Executive Director (ED) educated the department directors on the facility's Notices and Postings Policy and Procedure.

**2. Residents with the potential to be affected**

All residents have the potential to be affected by this deficient practice.

**3. Measures put in place to ensure the deficient practice will not re-occur**

The Housekeeping/ Maintenance Director will conduct weekly audits for three months beginning January 2026 of the front desk and lobby area to ensure all required postings remain in place.

**4. How will the facility monitor that the deficient practice is being corrected and will not reoccur? (Including frequency of monitoring, person responsible, and a completion date**

The Executive Director (ED) or designee will monitor the front desk and lobby area to ensure all required postings remain in place. Department directors will receive training on the facility's Notices and Postings Policy and Procedure upon hire.

**Completion date:** 1/12/2026

**ST- A 709 8:36-1.2(d) (1-18) Resident Assessments and Care Plans**

**(d) Each health care assessment by the registered professional nurse shall include, at a minimum, evaluation of the following:**



**1. Immediate Correction of Deficiency**

On 2/12/25 Resident went to the hospital to be evaluated. Resident #2 currently resides in the community. Resident #2 has [redacted] since the incident in [redacted] On [redacted] Resident #25 returned from the emergency room. Resident #25 no longer resides in the community he/she was discharged as of [redacted] Resident #30 currently resides in the community. He/she has not [redacted] since [redacted] The Consultant Administrator conducted an in-service for the Executive Director (ED) and the Director of Nursing (DON) on [redacted] The in-service topic was: NJ State Regulations for Resident Assessments and Plans of Care.

**2. Residents with the potential to be affected**

All residents have the potential to be affected by this deficient practice.

**3. Measures put in place to ensure the deficient practice will not re-occur**

A new policy was created by the administrative team entitled, Registered Nurse Assessment Policy and Procedure. This policy outlines the requirement that a Registered Nurse Assessment must be completed for all residents upon admission, semi-annually, and when a change in condition occurs in accordance with NJ 8:36- 7.2 (d) (1-18). The Executive Director will train the Director of nursing and all nursing staff on the new policy by 1/31/26.

**4. How will the facility monitor that the deficient practice is being corrected and will not reoccur? (Including frequency of monitoring, person responsible, and a completion date**

The Executive Director (ED) / Designee will conduct monthly audits for six months beginning February of 2026 to ensure that an RN Assessment that includes health conditions and preventive health measures, including, but not limited to, pain, falls, and lifestyle are completed for all residents upon admission. All nursing staff will be trained on the “Registered Nurse Assessment Policy and Procedure” annually and upon hire.

*Accepted*

**Completion date:** 1/31/2026

**ST- A 959 8:36-11.5(d) Pharmaceutical Services (d) Medication prescribed for one resident shall not be administered to another resident. Borrowing shall not occur.**

**1. Immediate Correction of Deficiency**

Disciplinary action was taken against the Administrator (ADM) who removed the [redacted] from another resident’s medication card and gave it to LPN # 4. Resident #30 did not experience [redacted] from the medication because LPN #4 recognized it as [redacted] and did not administer it to the Resident #30. Resident #30 currently resides in [redacted]



the facility. On 11/7/25 Director of Nursing (DON) educated all nursing staff on medication administration reminders, medication errors, and documentation reminders via email.

**2. Residents with the potential to be affected**

All residents have the potential to be affected by this deficient practice.

**3. Measures put in place to ensure the deficient practice will not re-occur**

On 11/7/25 Director of Nursing (DON) educated all nursing staff on medication administration reminders, medication errors, and documentation reminders via email. The DON also conducted an in-person meeting with all nursing staff on 11/7/25

Medication administration reminders included “The 6 Rights of Medication Administration”; additional safety checks (parameters) and the importance of remembering that borrowing of any medication or removing any labels from medication to give it to another resident any is considered misappropriation of medication.

**4. How will the facility monitor that the deficient practice is being corrected and will not reoccur? (Including frequency of monitoring, person responsible, and a completion date**

The Assistant Director of Nursing/ Designee will conduct medication administration observations weekly for three months beginning January 2026 to ensure medication is administered to only the resident for whom it was prescribed. All nursing staff will be trained on the “Medication Administration Policy and Procedure and the “Medication Error Reporting and Investigation Policy” annually and upon hire.

**Completion date:** 1/12/2026

*accepted*

**ST- A 985 8:36-11.7(b) Pharmaceutical Services (b) All medications shall be kept in their original containers and shall be properly labeled and identified.**

**1. Immediate Correction of Deficiency**

The medication refrigerator was inventoried by the Director of Nursing (DON) to ensure that there were no insulin pens that contained only the manufacturers label. All nursing staff was educated by the DON that all insulin pen’s labels must contain the resident’s name, name of medication, dose, route, and time by the DON. On 11/7/25 DON educated all nursing staff on medication administration reminders, medication errors, and documentation reminders via email.

**2. Residents with the potential to be affected**

17 of 17 residents identified by the facility as having orders for insulin have the potential to be affected by this deficient practice.



**3. Measures put in place to ensure the deficient practice will not re-occur**

On 11/7/25 Director of Nursing (DON) educated all nursing staff on medication administration reminders, medication errors, and documentation reminders via email.

Medication administration reminders included “The 6 Rights of Medication Administration”; additional safety checks (parameters). The Nurse manager will review the medication refrigerator weekly to ensure that all medication in that refrigerator is properly labeled.

**4. How will the facility monitor that the deficient practice is being corrected and will not reoccur? (Including frequency of monitoring, person responsible, and a completion date**

The Assistant Director of Nursing/ Designee will inspect the medication refrigerator weekly for three months beginning January 2026 to ensure all medication is properly labeled. All nursing staff will be trained on the “Medication Administration Policy and Procedure and the “Medication Error Reporting and Investigation Policy” annually and upon hire.

**Completion date:** 1/12/2026

*Accepted*

**ST- A 1051 8:36- 15.2 Resident Records**

**1. Immediate Correction of Deficiency**

The facility Resident Record Policy was reviewed and updated by facility’s administrative team. All staff was educated by the Executive Director on the proper maintenance and storage of resident records via all staff town hall meeting held on 11/13/25. One central location has been designated for resident record storage.

**2. Residents with the potential to be affected**

All residents have the potential to be affected by this deficient practice.

**3. Measures put in place to ensure the deficient practice will not re-occur**

On 11/13/25 Administrator educated all nursing staff on Resident Record policy and procedure and proper maintenance and storage of resident records. This policy includes all information that must be included in resident’s record; A current and complete health record for each resident in the assisted living residence that is receiving health care services; All records shall be kept available on premises for review at any time by representatives of the Department of Health; and All records shall be maintained for a period of ten years after discharge of resident from the assisted living residence.



**4. How will the facility monitor that the deficient practice is being corrected and will not reoccur? (Including frequency of monitoring, person responsible, and a completion date**  
The Director of Nursing/ Designee will conduct an audit of all resident records monthly for three months beginning January 2026 to ensure all resident records are present and complete. All nursing staff will be trained on the "Resident Record Policy annually and upon hire.

**Completion date:** 1/12/2026

*Accepted*

## STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 04A005	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 1/27/2026
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NAME OF FACILITY BENTLEY COMPREHENSIVE CARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 7999 NORTH ROUTE 130 PENNSAUKEN, NJ 08110
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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 A0389	Correction	ID Prefix A0709	Correction
Reg. # 8:36-3.4(a)(1)	Completed	Reg. # 8:36-4.1(a)(16)	Completed	Reg. # 8:36-7.2(d)(1-18)	Completed
LSC	01/12/2026	LSC	01/12/2026	LSC	01/31/2026
ID Prefix A0985	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:36-11.7(b)(1)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	01/12/2026	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 <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 11/7/2025		<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		

## STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 04A005	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 1/27/2026
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NAME OF FACILITY BENTLEY COMPREHENSIVE CARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 7999 NORTH ROUTE 130 PENNSAUKEN, NJ 08110
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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A0310	Correction	ID Prefix A0585	Correction	ID Prefix A0959	Correction
Reg. # 8:36-3.4(a)(1)	Completed	Reg. # 8:36-5.11(a)(6)	Completed	Reg. # 8:36-11.5(d)	Completed
LSC	01/12/2026	LSC	01/12/2026	LSC	01/12/2026
ID Prefix A0985	Correction	ID Prefix A1051	Correction	ID Prefix	Correction
Reg. # 8:36-11.7(b)(1)	Completed	Reg. # 8:36-15.2	Completed	Reg. #	Completed
LSC	01/12/2026	LSC	01/12/2026	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 <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 11/7/2025		<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		