

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 04A005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/09/2025
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NAME OF PROVIDER OR SUPPLIER BENTLEY COMPREHENSIVE CARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 7999 NORTH ROUTE 130 PENNSAUKEN, NJ 08110
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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: TYPE OF SURVEY: Complaint</p> <p>COMPLAINT #: NJ00185901, NJ00185651, NJ00185627, NJ00186121</p> <p>CENSUS: 108</p> <p>SAMPLE SIZE: 14</p> <p>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.</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

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A 310	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Complaint#: NJ 00185627</p> <p>Based on observation, interview, and record review, it was determined that the Administrator (Adm) failed to ensure the enforcement of the facility policy and procedures titled, "Notification and Documentation Protocol for Police-Involved Incidents" and "Documentation of Community Incidents in Point Click Care (PCC) and Resident Electronic Records" for 6 of 14 residents, Resident #'s 2, 5, 6, 7, 8, and #9. This deficient practice was evidenced by the following:</p> <p>1. On 5/9/25 at 10:20 a.m., the surveyor reviewed the closed medical record (MR) of Resident #2 which revealed that the resident moved in to the facility in NJ Ex Order 26.4b1 and moved on NJ Ex Order 26.4b1 with diagnoses of NJ Ex Order 26.4b1.</p> <p>Further review of Resident #2's MR, revealed a Progress Notes (PN) documented by the Director of Nursing (DON) on NJ Ex Order 26.4b1 at 11:27 a.m., that indicated, "... assessed for a NJ Ex Order 26.4b1 ... Both residents NJ Ex Order 26.4b1 themselves"</p> <p>2. At 11:00 a.m., the surveyor reviewed the MR of Resident #9 which revealed that the resident moved in to the facility in NJ Ex Order 26.4b1 with a diagnosis of NJ Ex Order 26.4b1. In addition, the surveyor reviewed Resident #9's "Service Plan (SP)" dated NJ Ex Order 26.4b1 which revealed</p>	A 310		
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A 310	<p>Continued From page 2</p> <p>the resident was NJ Ex Order 26.4b1 and was NJ Ex Order 26.4b1.</p> <p>At 11:30 a.m., the surveyor interviewed Resident #9 regarding the NJ Ex Order 26.4b1 with Resident #2 on NJ Ex Order 26.4b1. The resident stated that he/she went to visit a friend that resided in the NJ Exec Order 26.4b1 Resident #2, and at that time Resident #2 began to NJ Ex Order 26.4b1 to the resident if he/she did not NJ Exec Ord the apartment. Resident #9 also stated that nursing staff was notified.</p> <p>At 1:03 p.m., the surveyor interviewed the DON regarding the NJ Ex Order 26.4b1 documented in the PN between Resident #2 and Resident #9. The DON stated that on NJ Ex Order 26.4b1, Resident #9 reported that NJ Ex Order 26.4b1 occurred with Resident #2 and that NJ Ex Order 26.4b1 was called.</p> <p>At 1:42 p.m., the surveyor interviewed the Administrator regarding the NJ Ex Order 26.4b1 on NJ Ex Order 26.4b1. The Administrator stated that Resident #9 initially notified nursing that Resident #2 NJ Ex Order 26.4b1 resident NJ Ex Order 26.4b1 and with NJ Ex Order 26.4b1 told the resident to NJ Exec Ord the apartment. In addition, the Administrator stated that there were conflicting stories and he was not aware that NJ Ex Order 26.4b1 were called. The Administrator also confirmed that there was no report sent to the New Jersey Department of Health (DOH).</p> <p>On 5/16/25 at 3:04 p.m., the surveyor reviewed the NJ Ex Order 26.4b1 Investigation Report" which revealed that on NJ Ex Order 26.4b1 at 7:29 p.m., [Resident #9] called NJ Ex Order 26.4b1 and reported, " ... [Resident #2] NJ Ex Order 26.4b1 the resident on the NJ Ex Ord ... [Resident #9] NJ Ex Ord [Emergency Medical Services (EMS)]... Resident</p>	A 310		

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A 310	<p>Continued From page 3</p> <p>#9 advised [redacted] that there was [redacted] and refused EMS. ..."</p> <p>3. On 5/9/25 at 10:50 a.m., the surveyor reviewed the MR of Resident #5 which revealed that the resident moved into the facility in [redacted] with a diagnosis of [redacted]. In addition, the surveyor reviewed the PN dated [redacted] which revealed that a Certified Medication Aide (CMA) at 5:42 p.m. documented, "[Resident #8] [redacted] [Resident #5 and] ..[redacted]. The [redacted] were called to the scene to assist ...and the DON was notified."</p> <p>4. At 11:45 a.m., the surveyor reviewed the MR of Resident #8 which revealed that the resident moved into the facility in [redacted] with a diagnosis of [redacted]. During review of the MR, the surveyor observed that a CMA on [redacted] at 6:01 p.m., documented in the PN, "[Resident #8] was overheard [redacted] ... And then got into [redacted] [Resident #5]. The [redacted] were called... and DON was notified."</p> <p>At 1:13 p.m., the surveyor interviewed the DON regarding the [redacted] incident where Resident #8 [redacted] with Resident #5. The DON stated that Resident #8 was [redacted]</p> <p>At 1:42 p.m., the surveyor interviewed the Administrator regarding the [redacted]. The Administrator stated that he was notified that Resident #8 [redacted] and set it on the table. In addition, the Administrator confirmed</p>	A 310		

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A 310	<p>Continued From page 4</p> <p>that he did not report the incident to the NJDOH.</p> <p>On 5/16/25 at 3:15 p.m., the surveyor reviewed the [redacted] Investigation Report" which revealed that on [redacted] 4:38 p.m., [redacted] responded to the facility and documented, "...for a [redacted] between two residents involving [redacted] from [Resident #8's] [redacted] without incident. ..."</p> <p>5. On 5/9/25 at 11:15 a.m., the surveyor reviewed the MR of Resident #7 which revealed that the resident moved into the facility in [redacted] with diagnosis of [redacted].</p> <p>6. At 11:30 a.m., the surveyor reviewed the MR of Resident #6, which revealed that the resident moved into the facility in [redacted] with diagnoses of [redacted].</p> <p>At 1:23 p.m., the surveyor interviewed the Director of Nursing (DON) who stated that she was aware of Resident #6 and #7 [redacted] but was not aware of any [redacted] involvement.</p> <p>At 1:42 p.m., the surveyor interviewed the Administrator who stated that he was not aware of any incidents of [redacted] with Resident #'s 6 and #7. The Administrator stated that there were times when the residents called [redacted] themselves and didn't notify the staff. He also stated that [redacted] had not always notified the facility staff that they were on site at the facility.</p> <p>During continued interview, the Administrator</p>	A 310		

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A 310	<p>Continued From page 5</p> <p>stated that when the facility staff were made aware of any NJ Ex Order 26.4b1, incidents that required the residents to go out to the hospital for further evaluation, or that there was NJ Ex Order 26.4b1, the staff were required to notify the DON and the Administrator, and in addition, to complete an incident report.</p> <p>At 3:15 p.m., the surveyor interviewed Resident #7 who confirmed that he/she and Resident #6 had NJ Ex Order 26.4b1 regarding NJ Ex Order 26.4b1 about Resident #7. Resident #7 stated that NJ Ex Order 26.4b1 were called, but he/she was not sure who called them.</p> <p>On 5/16/25, the surveyor reviewed the NJ Ex Order 26.4b1 provided by the NJ Ex Order 26.4b1 regarding the incident with Resident#s 6 and #7 on NJ Ex Order 26.4b1, which revealed that the responding NJ Ex Order 26.4b1 spoke to the Executive Director (ED) and advised him of the complaint.</p> <p>The surveyor did not observe any documented evidence in the Progress Notes (PNs) for either Resident #6 or Resident #7 regarding the NJ Ex Order 26.4b1 to the incident that occurred on NJ Ex Order 26.4b1.</p> <p>On 5/19/25 at 3:04 p.m., the surveyor interviewed the ED via telephone who confirmed that he spoke to the NJ Ex Order 26.4b1 that responded to the incident on NJ Ex Order 26.4b1. The ED stated that he reported the incident to the Department of Health (DOH) and completed a Facility Reportable Event (FRE) (a form used by facilities to report events to the DOH). However, there was no documented evidence provided that the incident was reported to the DOH.</p> <p>The surveyor reviewed the undated facility policy</p>	A 310		

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A 310	<p>Continued From page 6</p> <p>titled, "Notification and Documentation Protocol for Police-Involved Incidents" which revealed, "Purpose: To establish a clear protocol for notifying the New Jersey Department of Health (NJDOH) ... In the event that the police are called to the building ...1. Immediate Notification: The Administrator, or their designee, must notify the New Jersey Department of (NJDOH) within 24 hours of the police involvement...."</p> <p>In addition, the surveyor reviewed the undated facility policy titled, "Documentation of Community Incidents in PCC and Resident Electronic Records" which revealed, "Purpose: To ensure consistent and accurate documentation of all incidents... 1. Incident Documentation Requirements: All incidents involving residents, staff, or visitors must be documented promptly... 2. Types of Incidents to Document: ... Behavioral Incidents...."</p>	A 310		
A 401	<p>8:36-4.1(a)(22) 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>22. The right to live in safe and clean conditions in a facility that does not admit more residents than it can safely accommodate while providing services and care;</p> <p>This REQUIREMENT is not met as evidenced</p>	A 401		

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A 401	<p>Continued From page 7</p> <p>by: Complaint#: NJ00185651</p> <p>Based on interview and review of records, it was determined that the facility failed to ensure a safe environment for 1 of 14 residents reviewed, Resident #3. This deficient practice was evidenced by the following:</p> <p>On [redacted] NJ Ex Order 26.4b1 The New Jersey Department of Health (NJDOH) received a Facility Reportable Event (FRE) (A form utilized by health care facilities to report events), that included a "date of event" of [redacted] NJ Ex Order 26.4b1 and a "Time of Event" of 10:00 p.m. The report revealed that Resident #3 reported an [redacted] NJ Ex Order 26.4b1 against Resident #2. The facility staff called [redacted] NJ Ex Order 26.4b1 and Resident #3 was transported to the hospital for further evaluation.</p> <p>On 5/6/25 at 10:00 a.m., the surveyor reviewed the Electronic Medical Record (EMR) of Resident #3 which revealed a move in date of [redacted] NJ Ex Order 26.4b1 and diagnoses including but not limited to [redacted] NJ Ex Order 26.4b1</p> <p>The surveyor reviewed Resident #3's signed facility document titled, "Resident Agreement" which indicated, "...Appendix C, RESIDENT'S BILL OF RIGHTS ... b. Every resident ...shall have the right to: ...(16) be free from physical and mental abuse and neglect ...(22) live in safe and clean conditions"</p> <p>At 11:47 a.m., the surveyor interviewed Resident #3, who stated that he/she received a text message from Resident #2, who had a move in date of [redacted] NJ Ex Order 26.4b1 and diagnoses of [redacted] NJ Ex Order 26.4b1 Resident #3 requesting he/she return to their shared room. Resident #3 stated</p>	A 401		
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A 401	<p>Continued From page 8</p> <p>that they had been roommate since he/she has been at the facility and they [redacted] NJ Ex Order 26.4b1 [redacted] Resident #3 also stated that they had [redacted] NJ Ex Order 26.4b1 [redacted]. Upon further interview, Resident #3 stated that he/she immediately went to the nurse's station after the [redacted] NJ Ex Order 26.4b1 [redacted], told the staff that [redacted] NJ Ex Order 26.4b1 [redacted] was [redacted] NJ Ex Order 26.4b1 [redacted] by Resident #2 and that the staff called [redacted] NJ Exec Order 26.4b1 [redacted].</p> <p>Upon further interview, Resident #3 stated that Resident #2 returned to the facility on [redacted] NJ Ex Order 26.4b1 [redacted] and knocked on the door of their [redacted] NJ Exec Order 26.4b1 [redacted] room. Resident #3 stated that he/she immediately left the room and went to the nurse's station to report that Resident #2 was back at the facility.</p> <p>At 1:03 p.m., the surveyor requested a timeline of the events and the facility's incident report, related to the FRE dated [redacted] NJ Ex Order 26.4b1 [redacted] from the Administrator (Admin) of the facility.</p> <p>At 1:10 p.m., the surveyor interviewed the Executive Director (ED), who stated that he received call from Resident #3, on his cell phone on [redacted] NJ Ex Order 26.4b1 [redacted] at 12:45 a.m., and stated that Resident #2 had returned to the building and knocked on the door of the room that both residents had [redacted] NJ Exec Order 26.4b1 [redacted]. The ED stated that he notified the Director of Nursing (DON) and facility security to call [redacted] NJ Ex Order 26.4b1 [redacted] to have Resident #2 [redacted] NJ Exec Order 26.4b1 [redacted] from the building. The ED also stated that he was not aware of any other time Resident #2 was present in the facility since [redacted] NJ Ex Order 26.4b1 [redacted].</p> <p>Additionally, the surveyor asked the ED what the facility's procedure was when a resident is no longer allowed in the building. The ED stated that he put a note and the resident's picture at the security desk advising staff that the resident was</p>	A 401		

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A 401	<p>Continued From page 9</p> <p>NJ Exec Order 26.4b1 in the facility. The ED also stated that he did not alert the staff that Resident #2 was NJ Exec Order 26.4b1 into the facility because he was notified by NJ Ex Order 26.4b1 that Resident #2 was not coming back to the facility.</p> <p>The ED did not provide the surveyor with the facility's policy regarding resident's rights.</p> <p>On 5/8/25 at 3:28 p.m., the surveyor interviewed a facility Certified Medication Aide (CMA) who stated that on NJ Ex Order 26.4b1 between the hours of 1:00 a.m.-2:00 a.m., Resident #3 asked the CMA if he/she could go to the hospital because he/she NJ Ex Order 26.4b1. The CMA stated that Resident #3 did not inform the CMA that he/she was NJ Ex Order 26.4b1.</p> <p>On 5/9/25 at 12:00 p.m., the surveyor reviewed the timeline of events provided by the ED which revealed that he received a call from Resident #3 on his cell phone on NJ Ex Order 26.4b1 at 12:32 a.m., and stated that Resident #2 had returned to the building. The ED also stated that he was not made aware of any other instance of Resident #2 entering the facility after his/her NJ Ex Order 26.4b1.</p> <p>On 5/15/24 at 11:00 a.m., the surveyor reviewed the NJ Ex Order 26.4b1 which revealed that Resident #3 stated to NJ Ex Order 26.4b1 that Resident #2 NJ Ex Order 26.4b1 Resident #3 on the NJ Ex Order 26.4b1 and told him/her to NJ Ex Order 26.4b1 on him/her. The report also revealed that Resident #3 then NJ Ex Order 26.4b1 of the room, down to the nurse's station.</p> <p>On 5/15/25, 5/16/25, and 5/19/25, the surveyor requested to obtain Resident #3's medical records from the hospital for date of service NJ Ex Order 26.4b1 without success.</p>	A 401		

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A 567	Continued From page 10	A 567		
A 567	<p>8:36-5.10(a)(4) General Requirements</p> <p>a) The facility shall notify the Department immediately by telephone at 609-633-9034 (609-392-2020 after business hours), followed within 72 hours by written confirmation, of the following:</p> <p>4. All alleged or suspected crimes which are serious crimes committed by or against residents, which have also been reported at the time of occurrence to the local police department;</p> <p>This REQUIREMENT is not met as evidenced by: Complaint#: NJ00185627</p> <p>Based on interview and record review it was determined that the facility failed to report an allegation of NJ Ex Order 26.4b1 immediately to the New Jersey Department of Health (NJDOH) for 2 of 14 residents reviewed, Resident #'s 6 and 7. This deficient practice was evidenced by the following:</p> <p>On 5/9/25 at 1:23 p.m., the surveyor interviewed the Director of Nursing (DON) who stated that she was aware of Resident's #'s 6 and #7 NJ Ex Order, but that she was not aware of any NJ Ex Order 26.4b1.</p> <p>At 1:42 p.m., the surveyor interviewed the Executive Director (ED), who stated that he was not aware of any incidents of NJ Ex Order 26.4b1 with Resident #'s 6 and #7. The ED stated that there were times when residents call NJ Ex Order 26.4b1.</p>	A 567		

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A 567	<p>Continued From page 11</p> <p>themselves without notifying facility staff. He also stated that [redacted] have not always notified facility staff that they were on site at the facility.</p> <p>Additionally, the ED stated that when the facility staff were made aware of any [redacted] any incidents that required the residents to go out to the hospital for further evaluation, or incidents when there is [redacted] the staff are instructed and are required to notify the DON and the ED, in addition to completing an incident report.</p> <p>At 3:15 p.m., the surveyor interviewed Resident #7, who stated that he/she and Resident #6, had a [redacted] regarding [redacted] about him/her. Resident #7 stated that the [redacted] were called but that he/she was not sure who called them.</p> <p>Resident #6 was not available for interview at the time of the survey.</p> <p>At 3:30 p.m., the surveyor reviewed the undated facility policy titled, "Notification and Documentation Protocol for Police-Involved Incidents" which revealed, "Purpose: To establish a clear protocol for notifying the New Jersey Department of Health (NJDOH) ... In the event that the police are called to the building ...1. Immediate Notification: The Administrator, or their designee, must notify the New Jersey Department of (NJDOH) within 24 hours of the police involvement"</p> <p>At 4:00 p.m. the surveyor reviewed the Medical Record (MR) of Resident #6 who had a move in date of [redacted] and diagnoses that included [redacted]. Review of the resident's MR revealed no documentation</p>	A 567		
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New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 04A005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/09/2025
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NAME OF PROVIDER OR SUPPLIER BENTLEY COMPREHENSIVE CARE LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 7999 NORTH ROUTE 130 PENNSAUKEN, NJ 08110
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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
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A 567	<p>Continued From page 12</p> <p>of an incident of NJ Ex Order 26.4b1 [redacted] to the incident that occurred on [redacted] between Resident #s 6 and 7.</p> <p>At 4:15 p.m. the surveyor reviewed the MR of Resident #7 who had a move in date of [redacted] and diagnoses of NJ Ex Order 26.4b1 [redacted]. Resident #7's MR revealed no documented evidence of a NJ Ex Order 26.4b1 incident nor a documentation that [redacted] responded to an incident on [redacted] involving Resident #s 6 and 7.</p> <p>On 5/16/25, the surveyor reviewed the [redacted] provided by the NJ Ex Order 26.4b1 regarding the incident with Resident #'s 6 and 7 on [redacted]. The [redacted] revealed that the responding NJ Ex Order 26.4b1 spoke to the Executive Director (ED) and advised him of the complaint the [redacted] received.</p> <p>Post survey on 5/19/25 at 3:04 p.m., the surveyor interviewed the ED via telephone and confirmed that he spoke to the NJ Ex Order 26.4b1 that responded to the incident on [redacted]. The ED stated that he reported the incident to The Department of Health (DOH) and completed a Facility Reportable Event (FRE) (A form utilized by health care facilities to report events to DOH). However, there was no documented evidence that the incident was reported to the NJDOH. The ED, during the survey on [redacted], did not provide documentation to confirm that the incident was reported to the NJDOH.</p>	A 567		
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Reviewed
9/26/25

PCC #4
Reviewed
9/25/25

Acceptable

Bentley Comprehensive Care, LLC

Bentley Comprehensive Care, LLC

NJ License 04A005

7999 Route 130 N

Pennsauken, New Jersey 08110

Plan of Correction for Complaint Survey Date: 05/09/25

ST -A-310-8:36-3.4(a)(1) Administration (a) 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; failed to ensure the enforcement of the facility policy and procedures title, "Notification and Documentation Protocol for Police Involved incidents" and "Documentation of Community Incidents in Point Click Care (PCC) and Resident Electronic Records."

Residents 1, 2, 4, 6, 10, 11, 13 all have been discharged from the building.

1. Immediate Correction of Deficiency

The Administrators/Designee and Director of Nursing (DON)/Designee were all re-educated by the Registered Nurse (RN) Consultant on the Policy and Procedures titled: "Notification and Documentation Protocol for Police Involved Incidences and Documentation of Community Incidents in Point Click Care (PCC) and Resident Electronic Records on 07/07/2025.



2. Residents with the potential to be affected

All residents have the potential to be affected.

3. Measures put in place to ensure the deficient practice will not recur

Facility Educator/Designee has in-serviced all nursing staff on the Policy and Procedures titled: "Notification and Documentation Protocol for Police Involved Incidences and Documentation of Community Incidents in Point Click Care (PCC) and Resident Electronic Records" on 07/07/2025.

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

Facility Educator/Designee will audit incident reports including police involved incidents on PCC once the incidents occur and are completed by the nursing staff completing the incident report weekly for one month and will be amended as necessary for compliance.

Completion Date: 07/30/2025

ST -A- 0401-8:36-4.1(a)(22) 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:

22. The right to live in safe and clean conditions in a facility that does not admit more residents than it can safely accommodate while providing services and care.

1. Immediate Correction of Deficiency

Resident# 2 was **NJ Ex Order 26.4b1** Resident #2 returned the same day and was **NJ Ex Order 26.4b1** the facility.



2. Residents have the potential to be affected

All residents have the potential to be affected.

3. Measures put in place to ensure the deficient practice will not recur

Facility Educator/Designee gave in-service on 07/08/25 for continuing education on sexual assault to all staff. A resident advocate has been made available to all residents to discuss any issues that residents feel uncomfortable about to immediately address all grievances and potential concerns from arising such as sexual assault. Resident #2 has been **NJ Ex Order 26.4b1** on premise.

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

The facility Administrator/Designee will ensure a real-time communication mechanism such as an internal messaging platform to ensure all room changes and roommate determinations are appropriate to promote and preserve resident safety.. A resident advocate staff will be designated to serve as a liaison for residents and facility administration to monitor any potential grievances to mitigate sexual advances/assaults.

Completion Date 07/30/2025

ST - A- 0567-8:36-5.10(a)(4) - General Requirements

- A) **The facility shall notify the Department immediately by telephone at 609-663-9034 or 609-392-2020 after business hours, followed by within 72 hours a written communication of the following:**
 - a) **All alleged or suspected crimes, which are serious crimes committed against Residents, which have also been reported at the time of occurrence to the local police department.**



1. Immediate Correction of Deficiency

The Administrators/Designee and Director of Nursing (DON)/Designee were all re-educated by the Registered Nurse (RN) Consultant on the Policy and Procedures titled: "Notification and Documentation Protocol for Police Involved Incidences and Documentation of Community Incidents in Point Click Care (PCC) and Resident Electronic Records on 07/07/2025.

2. Residents with the potential to be affected

All residents have the potential to be affected.

3. Measures put in place to ensure the deficient practice will not recur

The Administrator called the local police department on 07/07/2025 to notify the facility Administrator/Designee when they're onsite to ensure the deficient practice will not recur. Facility Educator/Designee has in-serviced all nursing staff on the Policy and Procedures titled: "Notification and Documentation Protocol for Police Involved Incidences and Documentation of Community Incidents in Point Click Care (PCC) and Resident Electronic Records" on 07/07/2025.

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

The Facility Educator/Designee will monitor all police involved incidents to ensure that the Administrator/Designee has reported such incidents to the Department of Health (DOH). In addition, the Resident Advocate has been designated to monitor and address concerns with the Administrators to ensure timely reporting.

Completion Date 07/05/2025

Submitted by NJ Ex Order 26.4b1

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

Facility Educator/Designee will audit incident reports including police involved incidents on PCC once the incidents occur and are completed by the nursing staff completing the incident report weekly for one month and will be amended as necessary for compliance.

Completion Date: 07/30/2025

ST -A- 0401-8:36-4.1(a)(22) 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:

22. The right to live in safe and clean conditions in a facility that does not admit more residents than it can safely accommodate while providing services and care.

1. Immediate Correction of Deficiency

Resident# 2 was **NJ Ex Order 26.4b1** the building by **NJ Ex Order 26.4b1** Resident #2 returned the same day and **NJ Ex Order 26.4b1** the facility.

2. Residents have the potential to be affected

All residents have the potential to be affected.

3. Measures put in place to ensure the deficient practice will not recur

Facility Educator/Designee gave in-service on 07/08/25 for continuing education on sexual assault to all staff. A resident advocate has been made available to all residents to discuss any issues that residents feel uncomfortable about to immediately address all grievances and potential concerns from arising such as sexual assault. Resident #2 has **NJ Ex Order 26.4b1** from the building and is **NJ Ex Order 26.4b1**

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

The facility Administrator/Designee will ensure a real-time communication mechanism such as an internal messaging platform to ensure all room changes and roommate determinations are appropriate to promote and preserve resident safety.. A resident advocate staff will be designated to serve as a liaison for residents and facility administration to monitor any potential grievances to mitigate sexual advances/assaults.

Completion Date 07/30/2025

ST - A- 0567-8:36-5.10(a)(4) - General Requirements

- A) The facility shall notify the Department immediately by telephone at 609-663-9034 or 609-392-2020 after business hours, followed by within 72 hours a written communication of the following:**
- a) All alleged or suspected crimes, which are serious crimes committed against Residents, which have also been reported at the time of occurrence to the local police department.**

1. Immediate Correction of Deficiency

The Administrators/Designee and Director of Nursing (DON)/Designee were all re-educated by the Registered Nurse (RN) Consultant on the Policy and Procedures titled: "Notification and Documentation Protocol for Police Involved Incidences and Documentation of Community Incidents in Point Click Care (PCC) and Resident Electronic Records on 07/07/2025.

2. Residents with the potential to be affected

All residents have the potential to be affected.

3. Measures put in place to ensure the deficient practice will not recur

The Administrator ^{when} called the local police department to notify the facility Administrator/Designee when they're onsite to ensure the deficient practice will not recur. Facility Educator/Designee has in-serviced all nursing staff on the Policy and Procedures titled: "Notification and Documentation Protocol for Police Involved Incidences and Documentation of Community Incidents in Point Click Care (PCC) and Resident Electronic Records" on 07/07/2025.

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

The Facility Educator/Designee will monitor all police involved incidents to ensure that the Administrator/Designee has reported such incidents to the Department of Health (DOH). In addition, the Resident Advocate has been designated to monitor and address concerns with the Administrators to ensure timely reporting.

Completion Date 07/05/2025

Submitted by **NJ Ex Order 26.4b1**

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 04A005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/09/2025
NAME OF PROVIDER OR SUPPLIER BENTLEY COMPREHENSIVE CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 #: NJ00185901, NJ00185651, NJ00185627, NJ00186121 CENSUS: 108 SAMPLE SIZE: 14 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	NJ Ex Order 26.4b1 NJ Ex Order 26.4b1 7/10/25	

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

TITLE

(X6) DATE

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 04A005	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 5/9/2025
NAME OF FACILITY BENTLEY COMPREHENSIVE CARE LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 7999 NORTH ROUTE 130 PENNSAUKEN, NJ 08110

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A0310	Correction	ID Prefix A0401	Correction	ID Prefix A0567	Correction
Reg. # 8:36-3.4(a)(1)	Completed	Reg. # 8:36-4.1(a)(22)	Completed	Reg. # 8:36-5.10(a)(4)	Completed
LSC	09/25/2025	LSC	09/25/2025	LSC	09/25/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY <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 5/9/2025		<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 		