New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04A005	A. BUILDING: ____ B. WING ____	C 06/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENTLEY ALP	**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: Monitoring CENSUS: 124 SAMPLE SIZE: 7 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		
A1505	8:36-23.3(a) Assisted Living Programs (a) Each assisted living program shall comply with the applicable provisions in N.J.A.C. 8:36-1 through 11, 13, 15 and 23. This REQUIREMENT is not met as evidenced by: A. Based on interview and record review it was determined that the Administrator failed to comply with Subchapter 3, N.J.A.C. 8:36-3.4(a)(1), which required the facility Administrator to ensure the development, implementation and enforcement of policies and procedures, for [Exec] of [Exec] residents reviewed, Resident #'s [Executive Order 26, 4.b.] and [Exec]. This	A1505		

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

New Jersey Department of Health

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A1505	Continued From page 1	A1505		

deficient practice was evidenced by the following:

1. On 6/17/19 at 9:45 a.m., the surveyor observed a report, dated 4/30/19, from the Consultant Pharmacist which was hanging on a bulletin board in the Wellness Center. The report documented recommendations for a total of Execu residents. The following residents were evaluated for implementation of these recommendations:

a. Resident Executi "...is Executive Order 26, 4.b. still needed" (prn is an abbreviation for as needed.)

b. Resident Execu, Executive Order 26, 4.b. "...suggested for long term Executive Order 26, 4.b. use."

c. Resident Executive O Please evaluate Executive Order with Executive Order 26, 4.b. diagnosis."

d. Resident Executi "Please evaluate Executive Order 26, 4.b.
Executive Order 26, 4.b.
Executive Order 26, 4.b.)

On 6/17/19 at 11:00 a.m., the surveyor interviewed the Director of Nursing (DON) who stated that he/she had never seen the pharmacy reports in the past. The surveyor then interviewed the Administrator who stated that he/she had not shown these reports to the DON. The surveyor reviewed each of the above mentioned residents' medical records and determined that although 6 weeks had elapsed, these recommendations had not been provided by the facility to the residents' Primary Care Physicians.

On 6/17/19 at 3:30 p.m., the surveyor requested the facility policy on consultant pharmacy reports and was told by the Administrator that the facility

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A1505	Continued From page 2	A1505		

did not have a policy regarding the time frame or procedures to be followed when the Consultant Pharmacist provided recommendations to the facility. The facility Administrator failed to ensure that a policy was developed and implemented.

2. On 6/17/19 at 12:30 p.m., the surveyor observed [Exec] prescriptions on a desk in the Wellness Center, both dated [Executive Order 26], for Executive Order 26, 4.b. and treatment due to Executive Order 26, 4.b. for Resident [Execut] and Resident [Executi]

The surveyor interviewed the DON who stated that the facility did not have anyone who routinely followed residents for Executive Order 26, 4.b. and that he/she was not aware whether these residents had been evaluated. The surveyor then reviewed the [Executive Order] Nursing Assessment documents for both Resident [Execu] and Resident [Execu], which documented that each "...resident has been referred to psych." Further review of the medical records did not disclose any documentation that the residents had in fact been seen.

At 3 p.m., the surveyor reviewed the facility policy, "Executive Order 26, 4.b. Referral," which documented, "Our wellness team will work with physicians to obtain Executive Order 26, 4.b. services as warranted." The Administrator failed to enforce this policy for the 19 day time period from the time the prescriptions were written until the date of this survey.

B. Based on record review and interview it was determined that the facility failed to comply with Subchapter 5, N.J.A.C. 8:36-5.1(a), for 2 of 7 residents reviewed, Resident [Execu] and Resident [Execu], which required the facility to coordinate personal care and services based on an assessment and the individual needs of each resident. This

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A1505	Continued From page 3 deficient practice was evidenced by the following: On 6/17/19 at 12:30 p.m., the surveyor observed Exec prescriptions on a desk in the Wellness Center, both dated Executive Order 26, for Executive Order 26, 4.b. consultation and treatment due to Executive Order 26, 4.b. for Resident Execu and Resident Executi. The surveyor interviewed the DON who stated that the facility did not have anyone who routinely followed residents for Executive Order 26, 4.b. issues and that he/she was not aware whether these residents had been evaluated. The surveyor then reviewed the 6/3/19 Nursing Assessment documents for both residents and observed documented for both Resident Execu and Resident Execu, "resident has been referred to Executive Order." Further review of the medical records did not disclose any documentation that the residents had in fact been seen. At 3 p.m., the surveyor reviewed the facility policy titled, Executive Order 26, 4.b. Referral" which documented, "Our wellness team will work with physicians to obtain psychological services as warranted." The DON failed to coordinate Executive Order 26, 4.b. services for these residents for the 19 day time period from the time the prescription was written until the date of this survey. C. Based on interview and record review it was determined that the facility failed to comply with Subchapter 7, N.J.A.C. 8:36-7.5 (e), which required the facility to ensure that each resident have an annual physical examination in accordance with state regulation, for Ex of Ex residents, Resident #'s Executive Order 26, 4 and Exec. This deficient practice was evidenced by the following: On 6/17/19 between 10:00 a.m. and 11:00 a.m., the surveyor reviewed medical records of Resident #'s Executive Order 26, 4 and Exec and observed the	A1505		

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A1505	Continued From page 4 following dates of physical examinations which exceeded the required annual physical examination: a. Resident [redacted] had a move in date of [redacted] with the last physical dated [redacted]. b. Resident [redacted] had a move in date of [redacted] with the last physical dated [redacted]. c. Resident [redacted] had a move in date of [redacted] with the last physical dated [redacted]. d. Resident [redacted] had a move in date of [redacted] with the last physical dated [redacted]. e. Resident [redacted] had a move in date of [redacted] with the last physical dated [redacted]. On 6/17/19 at 3:30 p.m., during surveyor interview with the Administrator, the Administrator stated that he/she believed that all physical examinations were within the required timeline but he/she was not able to provide documentation to confirm that these physical examinations had in fact been completed on a annual basis.	A1505		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
04A005		7/30/2019

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BENTLEY ALP	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 A1505 Reg. # 8:36-23.3(a) LSC	Correction Completed 08/19/2019	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	**REVIEWED BY (INITIALS)**	**DATE**	**SIGNATURE OF SURVEYOR**	**DATE**
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 6/17/2019	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			

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A 000	Initial Comments Initial Comments: TYPE OF SURVEY: Monitoring CENSUS: 124 SAMPLE SIZE: 7 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		
A1505	8:36-23.3(a) Assisted Living Programs (a) Each assisted living program shall comply with the applicable provisions in N.J.A.C. 8:36-1 through 11, 13, 15 and 23. This REQUIREMENT is not met as evidenced by: A. Based on interview and record review it was determined that the Administrator failed to comply with Subchapter 3, N.J.A.C. 8:36-3.4(a)(1), which required the facility Administrator to ensure the development, implementation and enforcement of policies and procedures, for [redacted] of [redacted] residents reviewed, Resident #'s [redacted] This	A1505		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Pamela [signature] TITLE: ED (X6) DATE: 7/19/19

New Jersey Department of Health

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A1505	Continued From page 1	A1505		

deficient practice was evidenced by the following:

1. On 6/17/19 at 9:45 a.m., the surveyor observed a report, dated [redacted] from the Consultant Pharmacist which was hanging on a bulletin board in the Wellness Center. The report documented recommendations for a total of [redacted] residents. The following residents were evaluated for implementation of these recommendations:

a. Resident [redacted] "...is prn [redacted] still needed" (prn is an abbreviation for as needed.)

b. Resident [redacted] blood work "...suggested for long term [redacted] use."

c. Resident [redacted] "Please evaluate [redacted] with [redacted] diagnosis."

d. Resident [redacted] "Please evaluate [redacted] meds for [redacted] [redacted] stands for [redacted] [redacted]

On 6/17/19 at 11:00 a.m., the surveyor interviewed the Director of Nursing (DON) who stated that he/she had never seen the pharmacy reports in the past. The surveyor then interviewed the Administrator who stated that he/she had not shown these reports to the DON. The surveyor reviewed each of the above mentioned residents' medical records and determined that although [redacted] weeks had elapsed, these recommendations had not been provided by the facility to the residents' Primary Care Physicians.

On 6/17/19 at 3:30 p.m., the surveyor requested the facility policy on consultant pharmacy reports and was told by the Administrator that the facility

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A1505	Continued From page 2 did not have a policy regarding the time frame or procedures to be followed when the Consultant Pharmacist provided recommendations to the facility. The facility Administrator failed to ensure that a policy was developed and implemented. 2. On 6/17/19 at 12:30 p.m., the surveyor observed 2 prescriptions on a desk in the Wellness Center, both dated [redacted] for [redacted] and treatment due to [redacted] for Resident [redacted] and Resident [redacted]. The surveyor interviewed the DON who stated that the facility did not have anyone who routinely followed residents for [redacted] issues and that he/she was not aware whether these residents had been evaluated. The surveyor then reviewed the [redacted] Nursing Assessment documents for both Resident [redacted] and Resident [redacted] which documented that each "...resident has been referred to [redacted]." Further review of the medical records did not disclose any documentation that the residents had in fact been seen. At 3 p.m., the surveyor reviewed the facility policy, "Psychology Referral," which documented, "Our wellness team will work with physicians to obtain psychological services as warranted." The Administrator failed to enforce this policy for the 19 day time period from the time the prescriptions were written until the date of this survey. B. Based on record review and interview it was determined that the facility failed to comply with Subchapter 5, N.J.A.C. 8:36-5.1(a), for [redacted] of [redacted] residents reviewed, Resident [redacted] and Resident [redacted] which required the facility to coordinate personal care and services based on an assessment and the individual needs of each resident. This	A1505		

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A1505	Continued From page 3	A1505		

deficient practice was evidenced by the following:

On 6/17/19 at 12:30 p.m., the surveyor observed 2 prescriptions on a desk in the Wellness Center, both dated [redacted] or [redacted] and treatment due to [redacted] for Resident [redacted] and Resident [redacted]. The surveyor interviewed the DON who stated that the facility did not have anyone who routinely followed residents for [redacted] and that he/she was not aware whether these residents had been evaluated. The surveyor then reviewed the [redacted] Nursing Assessment documents for both residents and observed documented for both Resident [redacted] and Resident [redacted], "resident has been referred to [redacted]. Further review of the medical records did not disclose any documentation that the residents had in fact been seen.

At 3 p.m., the surveyor reviewed the facility policy titled, "Psychology Referral" which documented, "Our wellness team will work with physicians to obtain psychological services as warranted." The DON failed to coordinate [redacted] services for these residents for the [redacted] day time period from the time the prescription was written until the date of this survey.

C. Based on interview and record review it was determined that the facility failed to comply with Subchapter 7, N.J.A.C. 8:36-7.5 (e), which required the facility to ensure that each resident have an annual physical examination in accordance with state regulation, for [redacted] of [redacted] residents, Resident #'s [redacted] This deficient practice was evidenced by the following:

On 6/17/19 between 10:00 a.m. and 11:00 a.m., the surveyor reviewed medical records of Resident #'s [redacted] and observed the

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A1505	Continued From page 4 following dates of physical examinations which exceeded the required annual physical examination: a. Resident [redacted] had a move in date o[redacted] with the last physical dated[redacted] b. Resident [redacted] had a move in date o[redacted] with the last physical dated [redacted] c. Resident [redacted] had a move in date of [redacted] with the last physical dated [redacted] d. Resident [redacted] had a move in date of [redacted] with the last physical dated [redacted] e. Resident [redacted] had a move in date of [redacted] with the last physical dated [redacted] On 6/17/19 at 3:30 p.m., during surveyor interview with the Administrator, the Administrator stated that he/she believed that all physical examinations were within the required timeline but he/she was not able to provide documentation to confirm that these physical examinations had in fact been completed on a annual basis.	A1505		

PLAN OF CORRECTION RESPONSES FOR June 17, 2019

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

Plan of Correction Date: 8/19/19

1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice; these are the residents specified in the Statement of Deficiencies (SOD).

   - Resident [redacted] review completed and agreed to keep [redacted]
   - Residen[redacted] review completed and agrees for [redacted] was [redacted] resident was [redacted]

     Resident [redacted] review completed and [redacted]
   - Resident [redacted] currently in the hospital and upon return medications will be reviewed by doctor.
   - Resident [redacted] is currently receiving services from [redacted]
   - Resident [redacted] was referred to [redacted] for services.

2. How the facility will identify other residents having the potential to be affected by the same deficient practice.

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

3. What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur.

- Consultant Pharmacist recommendations have been given to resident's APN, Doctor for review for approval or decline.
- New Policy was developed for consultant pharmacy recommendations and in-service with nursing department.

  Nursing staff in-serviced on sending resident that has prescription for psych service to helping hands or behavior health for services

4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not occur, i.e. what program will be put in place to monitor the continued effectiveness of the systemic change.
   - Nursing will bring completed Pharmacy report to QA meeting. Random audits by ED or DON will be completed for compliance prescription for psych services.

NJAC 8:36-5.1(a)

Plan of Correction Date: 8/19/19

1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice; these are the residents specified in the Statement of Deficiencies (SOD).
   - Resident [redacted] is currently receiving services from [redacted]
   - Resident [redacted] referred to [redacted] for services
2. How the facility will identify other residents having the potential to be affected by the same deficient practice.

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

3. What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur.
    a. Consultant Pharmacist recommendations have been given to resident's APN, Doctors for review for approval or decline.
    b. New Policy was developed and in-service with nursing department.
    c. Nursing staff in-serviced on sending residents that have a prescription for [redacted] service to [redacted] for services.

4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not occur, i.e. what program will be put in place to monitor the continued effectiveness of the systemic change.

- Consultant Pharmacist recommendations will be brought to QA for review and completion.
- ED and RN will meet weekly to discuss any new psych services needed for residents.

ID Prefix Tag NJAC 8:36-7.5(e)

Plan of Correction Date: 8/19/19

1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice; these are the residents specified in the Statement of Deficiencies (SOD).
    - Residen[redacted] completed on [redacted]

- Resident [redacted] completed on [redacted]
- Resident [redacted] resident [redacted] on [redacted]
- Resident [redacted] completed on [redacted]
- Resident [redacted] completed on [redacted]

2. How the facility will identify other residents having the potential to be affected by the same deficient practice.
    - All residents have the potential to be effected by this deficient practice.
3. What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur.
    - All charts were audited and spread sheet implemented with all resident dates for Annual Physicals.
    - The doctors have been given the paper work to complete for all out dated physical examinations.
4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not occur, i.e. what program will be put in place to monitor the continued effectiveness of the systemic change.
    - ED or DON will audit five random charts for compliance with annual physicals quarterly and report to QA.