

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 02C003	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/08/2023
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NAME OF PROVIDER OR SUPPLIER MASONIC VILLAGE AT BURLINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 902 JACKSONVILLE ROAD BURLINGTON, NJ 08016
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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 #: NJ00167080</p> <p>CENSUS: 76</p> <p>SAMPLE SIZE: 3</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 765	<p>8:36-7.4(c)(1) Resident Assessments and Care Plans</p> <p>(c) Written policies and procedures shall be developed and implemented to ensure, but not be limited to, the following:</p> <p>1. Assessment of all residents with a general service plan at least semi-annually, and those residents who have a health service plan shall be reassessed at least quarterly and more often on an as needed basis, including and upon the resident's return to the facility from the hospital;</p>	A 765		

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

TITLE

(X6) DATE

New Jersey Department of Health

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A 765	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #: NJ00167080</p> <p>Based on interview, observation and record review it was determined that the facility failed to reassess a resident upon return from hospitalization in order to determine the residents needs for 1 of 3 residents, Resident #2, reviewed for care and safety. This deficient practice was evidenced by the following:</p> <p>Resident #2's medical record (MR) revealed that Resident #2 moved into the facility on NJ ex order 26.4b1 with NJ ex order 26.4b1</p> <p>According to surveyor review of the facility's document titled, "Progress Notes" which revealed Resident #2 was NJ ex order 26.4b1 due NJ ex order 26.4b1.</p> <p>Further review of "Progress Notes" revealed that Resident #2 NJ ex order 26.4b1 and was escorted back by the local police department. The surveyor did not observe any documentation in the residents medical record that identified that the resident was assessed by the Registered Nurse (RN) upon return from the hospital.</p> <p>On 9/8/2023 at 10:42 a.m., during an interview with the Wellness Director it was confirmed that there was no documented evidence that a RN assessed Resident #2 upon return to the facility on NJ ex order 26.4b1.</p> <p>The facility failed to provide documented</p>	A 765		

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A 765	Continued From page 2 evidence that Resident #2 had been assessed by a RN upon his/her return to the facility from the hospital.	A 765		



902 Jacksonville Rd., Burlington, NJ 08016 • (609) 239-3900

September 21, 2023

Plan of Correction in response to a complaint survey on September 8, 2023.

PREFIX TAG A765 8:36-7.4 (C) (1) Resident Assessment and Care Plans

Criteria #1

Masonic Village of Burlington’s priority is the safety and care of our residents. During a complaint survey conducted on September 8, 2023, the Registered Nurse failed to document an assessment on one resident’s chart following their return from the hospital and [redacted] from the facility. The Registered Nurse assessed the resident following the [redacted] but failed to document their assessment in the chart. When this was brought to our attention, the resident’s service plan was immediately updated to reflect [redacted] protocols and [redacted] that were in place.

Criteria #2

Because all residents have the potential to be affected by this citation, we audited resident service plans for all of our current residents and found all other general and health service plans to be compliant.

Criteria #3

To enhance currently compliant operations and under the direction of the Wellness Director, all Assisted Living nursing team members will receive in-service training by 9/29/2023 reviewing our policy on Registered Nurse assessments. The training will emphasize the fact that a Registered Nurse must assess all residents with a general service plan on admission. Residents will be reassessed semi-annually and those residents with a health service plan shall be reassessed at least quarterly and more often on an as-needed basis, including upon resident’s return from the hospital, elopement, or change in condition.

Criteria #4

Our QAPI plan was revised under the direction of the Administrator to monitor compliance with the policy of resident assessments and care plans. The Administrator/Designee will audit charts for all residents returning from the hospital or experiencing condition changes to ensure ongoing compliance with Registered Nurse assessments for the next 30 days. Any deficiencies noted will be brought to the attention of the Administrator. The results of the observations will be reviewed at our quarterly QAPI meeting.

With warm regards,

[redacted signature]

Cedar Commons Administrator
[redacted name]

LICENSING

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 02C003	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 9/8/2023
Y1	Y2	Y3
NAME OF FACILITY MASONIC VILLAGE AT BURLINGTON		STREET ADDRESS, CITY, STATE, ZIP CODE 902 JACKSONVILLE ROAD BURLINGTON, NJ 08016

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	DATE	ITEM	DATE
Y4	Y5	Y4	Y5
ID Prefix <u>A0765</u>	Correction	ID Prefix _____	Correction
Reg. # <u>8:36-7.4(c)(1)</u>	Completed	Reg. # _____	Completed
LSC _____	09/29/2023	LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed
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 9/8/2023
 CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?

 YES NO