STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315166	A. BUILDING ______ B. WING ______	C 09/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MASONIC VILLAGE AT BURLINGTON	**902 JACKSONVILLE ROAD BURLINGTON, NJ 08016**

(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) COMPLETION DATE
F 000	INITIAL COMMENTS COMPLAINT#: NJ146664 Census: 101 Sample Size: 3 THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: C#: NJ146664 Based on interviews, medical record review, and review of other permanent facility documents on 8/23/2021 and 9/1/2021, it was determined that the facility failed to follow the Physician's Orders (PO's) for medication administration. The facility also failed to follow its policy titled "Medication Administration" for 1 of 3 residents (Resident #2). This deficient practice was evidenced by the following: Review of the "Electronic Medical Record" (EMR)	F 658	This Plan of Correction constitutes our written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. PREFIX TAG: Professional Standards (483.21(b)(3)(i) Criteria #1 At Masonic Village of Burlington, it is our	10/1/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 09/21/2021

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 658	Continued From page 1 were as follows: According to the "Resident Face Sheet," Resident #2 was admitted to the facility on [redacted], with diagnoses which included but were not limited to: [redacted] According to the Minimal Data Set (MDS), an assessment tool dated [redacted], Resident #2 had a Brief Interview for Mental Status (BIMS) score of [redacted], indicating the resident was [redacted]. The MDS also showed that Resident #2 needed assistance with Activities of Daily Living (ADLs) and received [redacted] medications. Review of Resident #2's Care Plan (CP) dated [redacted], showed under "Focus": Resident #2 receives [redacted] medication for [redacted]. Under "Goals," Resident #2 will be free from complications of [redacted] medications. Under "Interventions": Change the battery on [redacted] and [redacted] days. Change [redacted] administration bag weekly. [redacted] as ordered. A review of Resident #2's nursing Progress Notes (PN) dated [redacted] at 3:40 PM revealed that the resident had [redacted]). Further review of Resident #2's PN dated [redacted] at 5:34 PM revealed the resident did not receive his/ her [redacted] as prescribed by the Physician. According to the PN, the [redacted] of [redacted] was noted to be full during the weekly	F 658	goal to provide excellent care consistent with established nursing standards. During this survey, a retrospective review of one resident record revealed that an [redacted] medication being administered via an [redacted], failed to deliver the full prescribed dosage of medication to the resident. The documentation in the Medication Administration Record was found to be inconsistent and on 4 days of the resident's 25 day stay, [redacted] weight was not recorded in the medical record. As soon as the nursing team became aware of a potential issue with the [redacted] not delivering the correct dosage of medication, the company supplying the medication and [redacted] was notified and a replacement [redacted] ordered. The resident's attending physician was notified of the issue and instructed the team to continue monitoring the resident. The resident did have a weight gain and when reviewing records, the nurse manager did notice missing weight documentation. The nursing team notified the physician and follow up orders were obtained and acted on immediately. The nurses who were assigned to care for this resident during the time that the [redacted] was not working properly, were counseled and re-educated on the need to check the contents of the [redacted] bag in conjunction with the data on the [redacted] to ensure that the medication is [redacted] properly. The importance of obtaining daily weights and following through as needed was also reviewed with all team members.	

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Continued From page 2

bag change, and only a quarter of the [redacted] was [redacted] The PN also showed that a message was left for the doctor [redacted] to notify him of the missed doses. The attending Physician was also notified, and there were no new orders.

A review of Resident #2's PO's dated [redacted] were as follows:

[redacted] route every shift continuously. Diagnosis: [redacted], dated [redacted].

Monitoring daily weights every day at 7:00 AM, dated [redacted].

Review of Resident #2's Medication Administration Record (MAR) dated [redacted] and [redacted] showed no documentation of initials from [redacted] on the 3-11 shift through [redacted] on the 11-7 shift, indicating the [redacted] was being administered. The MAR also showed no documentation of weights for [redacted], [redacted] and [redacted].

A review of Resident #2's weight sheet showed no documentation of the above missing weights. Further review of the weight sheet showed from [redacted] through [redacted], during the time of the resident not receiving his/her [redacted] the resident had an [redacted] weight gain as follows:
[redacted]

Review of Resident #2's "Accidents/Incidents Report" dated [redacted], revealed under

F 658

Criteria #2
Because all residents could be affected by this deficient practice, the medical records of all residents who are ordered to have daily weights monitored, and/or have an [redacted] were audited to ensure proper documentation and that orders were being carried out as written. All were found to be compliant.

Criteria #3
To enhance currently compliant operations and under the direction of the Director of Nursing and in cooperation with the community Education Manager, all professional nurses who work on the skilled units were given written documentation/information on [redacted] [redacted]/medication administration. A quiz accompanied this education as proof of understanding the content. All newly hired nurses for skilled nursing will receive in-service training reviewing our policy on [redacted] medication administration during their initial orientation and the importance of weight obtainment for optimal resident care. All newly hired C.N.A.s will receive in-service training reviewing our policy on weights during their initial orientation emphasizing the importance of this information for resident care and health. Nurses and C.N.As were inserviced on the importance of obtaining and documenting daily weights if ordered and proper follow-up action based on the results.

Criteria #4
Our QAPI plan was revised under the

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F 658	Continued From page 3 "Pertinent Health Status Information": . The Accident/Incident Report also revealed that the was due for its weekly change when the bag was noted to be full, resulting in missed doses of the medication. Review of Resident #2's "Medication Error Incident Report" dated , indicated under "Description of Incident": Medication changed on , was noted to have multiple doses that were not over a week timeframe from through During an interview on 8/23/2021 at 11:06 AM, the Assistant Director of Nursing (ADON) stated, Resident #2 has and is on a . The ADON also stated the continuously 24 hours a day, and it's a , which the resident will need for the rest of his/her life. The ADON explained that on , "we noticed that the wasn't working when the resident's family member came in and noticed that the resident had some of the medication left over." According to the ADON, the did not alarm, which would have indicated the was not infusing. The ADON also explained that the resident had some extra weight gain. Hence, the doctor adjusted the resident's (medications to help the . During an interview on 8/23/2021 at 12:46 PM, the Director of Nursing (DON) stated, Resident #2's weight gain could have been from the resident not receiving the medication. The DON also stated increases the the and helps with .	F 658	direction of the Administrator to monitor compliance with the application of current accepted practices related to medication administration and obtaining daily weights. The Nurse Manager(s)/Designee(s) will review the charts of all residents who have orders for daily weights to ensure full compliance with completion of this task and proper follow through in the event of unexpected findings for a period of three months. Residents ordered to receive medications will also be observed by the Nurse Manager(s)/Designee(s) for three months to ensure compliance with the department policy. Any deficiencies noted will be brought to the attention of the Director of Nursing. Daily weight completion, documentation, and compliance with policies regarding medication administration will be periodically audited thereafter and more frequently if needed based on results of the audit. Results of the observations will be reviewed at quarterly QAPI meetings.	

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The surveyor made multiple attempts to contact the staff assigned to Resident #2 when the medication errors occurred. However, there were no responses. Messages were also left with Resident #2's [redacted] receptionist on [redacted], but the surveyor received no return calls.

A review of the facilities policy titled "Medication Administration" dated 10/5/2019 indicated the following: Under "Policy Statement,": Medications shall be administered in a safe and timely manner and as prescribed. Under "Policy Interpretation and Implementation" #3. Medications must be administered in accordance with orders, including any required timeframe. #7 The individual administering the medication must check the label three (3) times to verify the right resident, right medication, right dose, right time, and right method (Route) of administration before giving the medication.

N.J.A.C.: 8:39-27.1