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	315166	A. BUILDING _____ B. WING _____	C 06/30/2023

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MASONIC VILLAGE AT BURLINGTON	902 JACKSONVILLE ROAD BURLINGTON, NJ 08016

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E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
F 000	INITIAL COMMENTS Complaint NJ #: 159009; 160807; 161324; 162044 Survey Date: 6/30/23 Census: 82 Sample: 20 + 3 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	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: Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to a.) clarify and accurately transcribe a physician's order for an EX Order 26.4B1 EX Order 26.4B1); b.)	F 658	PREFIX TAG: F658; 483.21(b)(3)(i); Services Meet Professional Standards Criteria #1 At Masonic Village of Burlington, it is our	7/28/23

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

Electronically Signed | 07/20/2023

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 document the administration of the [EX Order 26.4B1] c.) obtain physician's orders in accordance with professional standards of practice for [NJ Exec. Ord] for the flushing of water before and after medication pass and checking residual to ensure accountability and consistency. The deficient practice was identified for 2 of 20 residents reviewed for professional standards of practice (Resident #43 and #778) and was evidenced by the following: Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board The nurse practice act for the State of New Jersey states; "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist."	F 658	goal to provide our residents with excellent care in accordance to all professional standards. During our Annual Re-Certification survey, it was discovered that while a resident did receive an [EX Order 26.4B1] as ordered by the physician, the nurse failed to ensure that the order was written in the medical record and that documentation of the administration of the [EX Order 26.4B1] was completed. Also, although the nursing staff were managing a resident's feeding tubes correctly, physician orders were not written in the chart to direct this management. As soon as this was brought to our attention, proper orders for the [EX Order 26.4B1], and instructions for the management of the feeding tubes were placed in the residents records. Criteria #2 Because all residents could be affected by this deficient documentation practice, a review of all resident records commenced, and it was found that orders for all provided care were present. Criteria #3 To enhance currently compliant operations and under the direction of the Administrator and Director of Nursing, all professional nurses will receive in-service training reviewing our policy on accepting and writing verbal orders. The importance of having written records of all orders and documentation of the follow through with these orders including the timely sign off on the MAR/TAR indicating	

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F 658	Continued From page 2 1. On 6/21/23 at 10:23 AM, the surveyor observed Resident #43 sitting in their chair eating breakfast. At this time, Resident #43 advised that they were admitted to the facility on a Thursday and went back to the hospital that Saturday for a EX Order 26.4B1. The resident reported to the surveyor that they informed the facility upon admission they have not had a EX Order 26.4B1 and was told that it was a result of the EX Order 2 medication. The surveyor reviewed the medical record for Resident #43. A review of the Admission Record face sheet (an admission summary) reflected the resident was admitted to the facility in EX Order 26.4B1 with diagnoses which included EX Order 26.4B1 of the EX Order 26.4B1 A review of the admission Minimum Data Set (MDS), an assessment tool dated EX Order 26.4B1, reflected a brief interview for mental status (BIMS) score of EX Order 26.4B1 which indicated a EX Order 26.4B1. A review of the Physician Progress Notes included a note dated EX Order 26.4B1 that indicated no EX Order 26.4B1 since EX Order 26 give EX Order 26.4B1 EX Order 3 EX Order 26.4B1 today. The note did not include if the EX Order 26.4B1 was administered. A review of the EX Order 26.4B1 Physician Summary Report did not include the one time order for the EX Order 26.4B1 ordered by the Physician on EX Order 26.4B1	F 658	the completion of the task will be emphasized. Our policy and procedure on receiving, documenting and follow through including documentation required for all physician orders will be updated and included in staff re-education. Criteria #4 Our QAPI plan was revised under the direction of the Administrator to monitor compliance with the policy for handling of verbal orders and the subsequent documentation of such. The Director of Nursing/Designee will review all orders for newly admitted residents with a feeding tube in place each month for the next 6 months to ensure proper orders for the management of the feeding tube are in place and that the interventions are documented appropriately. Three (3) resident charts will be reviewed each week for the next 4 weeks to compare practice to orders to ensure that all enteral feeding orders are present in the record. Any deficiencies noted will be brought to the attention of the appropriate Manager/Supervisor and staff member. Results of the observations will be reviewed at our monthly QAPI meeting.	

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F 658	Continued From page 3 A review of the corresponding EX Order 26.4B1 Treatment Administration Record (TAR) and Medication Administration Record (MAR) did not include the administration of the EX Order 26.4B1 on EX Order 26.4B1 or EX Order 26.4B1 On 6/26/23 at 10:24 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) who confirmed that the nurses were responsible for putting in physician orders. On 6/25/23 at 12:47 PM, the surveyor interviewed Unit Manager/Licensed Practical Nurse (UM/LPN #1) who confirmed there was documentation that the order for the EX Order 26.4B1 was entered, reconciled, or even that the order was relayed to the nurse and administered. When asked who had the responsibility for transcribing physician orders, the UM/LPN #1 stated everyone had the responsibility to make sure orders were transcribed. On 6/26/23 at 1:38 PM, the surveyor interviewed the Director of Nursing (DON) who confirmed that there was no documentation that the order for the EX Order 26.4B1 was carried out. When asked who had the responsibility for transcribing physicians orders the DON stated, "the nurse that is assigned typically." On 6/28/23 at 10:40 AM, the Licensed Nursing Home Administrator (LNHA) in the presence of the DON, stated that the resident received the EX Order 26.4B1, as ordered by the Physician, but the nurse forgot to input the physician order into the medical record as well as document the administration of the EX Order 26.4B1. The LNHA further stated that she spoke to the resident who	F 658		

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F 658	Continued From page 4 confirmed the EX Order 26.4B1 was administered as ordered, as well as the resident requested to be transferred to the hospital instead of receiving a EX Order 26.4B1 on EX Order 26.4B. On 6/30/23 at 9:30 AM, LNHA in the presence of the DON, Administrator in Training, and survey team confirmed that the nurse who received the verbal order was responsible for putting into the medical record. The LNHA continued anytime a verbal order was taken it should be documented, input on the MAR and TAR, and documented as administered. A review the facility's "Telephone and Verbal Orders" policy dated 1/5/21 and last reviewed on 1/9/23, included...2. Verbal orders are those given by an authorized practitioner directly to a person authorized to receive and transcribe order on his or her behalf. 4. The individual receiving the verbal order must write it on the physicians order sheet as "v.o." (verbal order) or "t.o." .... 2. On 6/22/23 at 9:30 AM, the surveyor observed Resident #778 lying in bed watching television and who stated that he/she was doing okay, and everything was fine. At that time, Licensed Practical Nurse (LPN #1) informed the surveyor and the resident that the EX Order 26.4B1 was completed and would go back up at 3:00 PM. LPN #1 then took down the empty bottle of EX Order 26.4B EX Order 26.4B1); and placed a clean white towel on top of the resident's EX Order 26.4B1 near the EX Order 26.4B1 EX Order 26.4B1	F 658		

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for [NJ Exec. Order 26.4.b]) to prevent any leakage. LPN #1 took out her stethoscope and used a disinfectant wipe to clean it. She informed the resident she was going to listen for the placement of the [EX Orde]. She then used a syringe and checked the gastric residual volume. She then informed the resident she was going to administer the medication EX Order 26.4B1. LPN #1 grabbed a four ounce (4 oz) plastic cup filled with water and poured some of the water down the [EX Ord] and informed the resident she was flushing the [EX Orde] with water. She then administered the EX Order 26.4B1 crushed mixed with water into the [EX Order] LPN #1 then grabbed the 4 oz plastic cup again and poured some more water into the [EX Orde]. LPN #1 stated that she was flushing with water again. She then informed the resident she was going to change her gown and gloves to change the [EX Orde] dressing.

The surveyor reviewed the medical record for Resident #778.

A review of the Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility EX Order 26.4B1, with diagnoses which included EX Order 26.4B1 EX Order 26.4B1 EX Order 26.4B1 EX Order 26.4B1.

A review of the Order Summary Report (OSR) for EX Order 26.4B1 included the following physician's orders (PO) for EX Order 26.4B1

A PO dated [EX Order 26.4B1], to administer [EX Order 26.4B1] at a rate of [EX Orde] milliliter per hour ([EX Orde] mL/hr) for [EX Order 26.4B] hours for a total volume of [EX Order 26] mL; hang up at

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F 658	Continued From page 6 3:00 PM. A PO dated EX Order 26.4B1, to administer a water flush of EX Order mL of water every EX Ord hours. The OSR did not in PO for the checking of residual as observed by LPN #1 or the water flush administered with medication administration. A review of the individualized comprehensive care plan (ICCP) included a focus area initiated EX Order 26.4B1, that the resident was at NJ Exec. Order 26:4.b.1 as evidenced by diagnosis of EX Order 26.4B1 [redacted] Interventions included to monitor EX Order 26.4B1 NJ Exec. Order 26:4.b.1 [redacted] after each scheduled feeding as resident will allow and to administer EX Order 26.4B1 a rate of EX Ord mL/hr for a total volume of EX Order 26 mL with EX Order mL water flushes every EX Ord hours. The ICCP did not include the amount of residual to monitor for or to notify the physician of a certain amount of residual. The ICCP also did not include the water flushes observed during medication administration. On 6/23/23 at 10:41 AM, the surveyor interviewed LPN #1 who stated that the process for tube feeding included performing hand hygiene, putting on a pair of gloves, using a syringe to check the residual and the placement which was a physician's order (PO). She then stated that the nurses flushed the FT with water with the amount specified in the PO which was given before and after each medication. She stated that if the medication was appropriate to be crushed, it would be mixed with water and	F 658		

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F 658	Continued From page 7 flushed again with the ordered amount of water. LPN #1 stated that she believed there was a PO in the electronic medical record (EMR) as she thought she signed off on it. She further stated it would have to be a PO to "show it was done." On 6/23/23 at 10:44 AM, LPN #1 and the surveyor reviewed the EMR together. LPN #1 stated that there were orders to flush [redacted] mL of water every [redacted] hours and for the [redacted] at [redacted] mL/hour for [redacted] hours only. LPN #1 confirmed the EMR did not include a PO for how much water to flush between medications, for monitoring the residual, and checking the placement. LPN #1 stated that the residual and placement she just did automatically. At that time, LPN #1 continued to review the EMR and confirmed she did not see any active orders or discontinued orders for water flushes before and after medications, monitoring the residual, and checking the placement. LPN #1 stated that there should be orders for the water flushes before and after medication administration, monitoring the residual, and checking the placement. LPN #1 stated that it was important to ensure the nurses were not over flushing the resident and gave the ordered amount of water, in addition to checking for placement to ensure the [redacted] was in the proper place, and the residual to ensure the resident was appropriately digesting the feeding. On 6/23/23 at 10:54 AM, the surveyor interviewed UM/LPN #2 who stated that the process for tube feeding included to ensure the tubing was patent (unobstructive). UM/LPN #2 stated that they flushed with 10 mL of water before and after each medication. She further stated that the nurse had to first check placement	F 658		

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as you want to hear a "whoosh sound" that assured the tube was in place. UM/LPN #2 stated you then checked for any residual to ensure the feeding was working. She confirmed a PO was needed to check residual and placement as well as for water flushes before and after a medication. She stated that it was important to ensure there were POs for these to ensure the tubing was functioning like it was supposed to. She further stated that the POs were important so everyone knew what to do for that resident. UM/LPN #2 emphasized you "have an order for everything."

The surveyor continued to review the medical record.

A further review of the OSR after surveyor inquiry revealed the following after surveyor inquiry:

A PO dated [redacted], to check placement of the [redacted] before beginning a feeding and before administering medications. Notify MD if placement is not confirmed every shift.
A PO dated [redacted], to flush [redacted] with [redacted] mL [redacted] water prior to all medication administrations to check correct placement of [redacted] every shift.

The PO did not include to administer water flushes after medication administration or between each medication.

On [redacted] at 12:18 PM, UM/LPN #2 stated in the presence of the survey team, that the facility followed the [company's name redacted] manual for new hires which was located on each nursing unit. She stated that all of the unit managers had one, and that the facility conducted in-services

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when things changed and provided the surveyor with in-service conducted on 5/22/23 to 5/29/23. UM/LPN #2 acknowledged that there should have been orders for water flushes before and after medication administration and checking the residual. UM/LPN #2 confirmed she had entered the PO in the EMR after surveyor inquiry.

On 6/26/23 at 10:55 AM, the surveyor interviewed the DON who stated that the process for tube feeding included that they referred to the facility's policy and procedures in following the steps. She stated that the steps included checking for placement, checking for residual, and flushing the tube with 30 mL to 60 mL of water before and after the mediation administration. She then stated that you would mix the medication in water and ensure it was thin enough to be administered through the feeding tube. She further stated that they used gravity to administer the medications, but occasionally they would push with a 60 mL syringe if needed. The DON again stated they referred to the policies and some of it was simply "nursing judgement as we all learned it in nursing school." She further stated unless it was something different than normal or unexpected, then they needed an order such as if the resident was on a fluid restriction or different quality of gastrointestinal issues. When asked would you need a physician's order for checking the placement, checking the residual, and flushes before and after the administration of medication? The DON stated, "it would be a good reminder to have an order, but I would expect the nurses to know the standard of practice with feeding tubes." She again stated she would not expect to have a physician's order for the water

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flushes before and after medications; checking the residual and placement as that was all a standard of practice.

On 6/26/23 at 11:04 AM, the surveyor asked the DON about UM/LPN #2 entering a physician's order after surveyor inquire. The DON stated after the surveyor talked to UM/LPN #2, "they thought that moving forward it would be good to add those orders in" and to show it was done.

On 6/26/23 at 11:27 AM, the surveyor interviewed the LNHA who stated that "physicians had to provide orders for anything that we are doing to the residents." The surveyor asked did they need a physician's order for the checking the placement of the FT, checking the residual of the FT, and water flushes before and after medication administration with a FT. The LNHA stated that if they deemed necessary, they would obtain a physician's orders but that it was "nursing standard of practice" to make sure they were checking the placement and that it was intact, flushing the tube checking for patency and checking the residual to ensure "we are not over feeding the resident and they are tolerating the feeding." The LNHA emphasized that they just considered that checking placement, checking residual and flushes before and after medication as nursing standard of practices and did not need a physician's order."

On 6/27/23 at 11:26 AM, the surveyor interviewed the Medical Director (MD) via telephone who stated that the nursing staff should be following the protocol for tube feedings which included checking the placement, checking the gastric residual, and flushing the tube. He stated that it

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was important to follow the protocol as it would let the physician know if the resident tolerated the feeding, the placement to ensure it was not dislodged, and the flushes to ensure it was not clogged. He further stated following those protocols ensured there were no issues with the tube. When asked was a physician's order required, the MD replied that he was not sure if a PO was needed. The MD again stated it was important to know and follow the protocol. The MD stated that for the free water flushes, there should be a PO. He further stated that the POs varied from each resident based on their needs when it came to the flushes. The MD then stated that the flushes before and after medication was a small amount of 10 to 20 mL to ensure the tube was not clogged. When asked was an order required for the before and after medications, the MD again stated he was not sure if a PO was needed as that was a "nursing practice." He further stated that checking for placement and residual was part of the examination, and when they documented it that would be their accountability. The MD concluded everyone worked together for the care of the resident. The surveyor asked for clarification on if a PO was needed to ensure there was accountability, and the MD was unable to provide clarification.

On 6/27/23 at 11:37 AM, the surveyor interviewed the DON again who stated if it was not in a PO, then they did not have to document to ensure accountability. The DON stated, "as professional nurses we need to make the assumption that it is getting done and that there needs to be an understanding that the nurses are doing the job they are trained for." The DON confirmed that if care was not documented then there would be no

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way to ensure accountability. She then stated that if a resident on was on fluid restrictions, then there would a PO for the specific amount, but a resident was not on fluid restrictions then they would base it off their policy which indicated to flush the tube with 30 to 60 mL before and after medications. The DON emphasized "I would hope they are following the policy." She then stated that if a resident was not on fluid restrictions, then they would not be concerned about tracking the fluid amount.

On 6/28/23 at 9:33 AM, the surveyor interviewed the Consultant Pharmacist (CP) via the telephone who stated that she was out on leave for three months, and it was her first week back. She stated that prior to her leave, she had the nurses complete an in-service on tube feedings she thought in January or February of 2023. The surveyor continued to interview the CP regarding residents that required tube feedings. The CP stated that if a resident was on a tube feed, she looked to ensure that there were actual orders of tube feeding as well as water flushes. She further stated that some facility had orders for flushes 30 mL before and after medications with a minimal of five (5) mL between each medication being administered. The CP stated that it was standard of practice to flush the tube with 30 mL before and after medication administration and should be reflected in the facilities' policies. The CP stated that based on her understanding, some facilities did not require an order because it was considered a standard of practice. She stated that during her in-service, she informed her nurses to flush the tube before and after medication administration with the 30 mL of water unless the resident was on fluid restrictions. The

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CP further stated that if there was no specific order for it, then they should be following the protocol standard of practice for checking the placement, checking the residual and the flushes. The CP then stated that it would be "best practice if they had an order to ensure accountability" but again stated that not all facilities required to have orders in place for the standard of practice. The CP stated, "it would be nice to have those orders in place." The CP stated she did not discuss a lot with the nurses regarding tube feed as the facility did not have a lot of residents on tube feedings. The CP stated that if there was not a PO, then there would be no way to ensure accountability. The CP acknowledged there should be a way to ensure accountability in a form of a PO or documentation regarding the checking of the placement, residual and flushes. At that time, the CP was unable to speak on any additional information and stated that there should be some type of way to ensure accountability.

On 06/28/23 at 10:03 AM, the surveyor interviewed the Registered Dietician (RD) who stated that with the tube feeding she made sure the weights were stable, the residents were tolerating the feed, that there was no residual, and that they were tolerating the formula. She further stated that with the tube feedings she monitored those residents monthly instead of quarterly. The surveyor continued to interview the RD who stated that the nurses monitored the residual. She stated that the nurses documented in the progress note how the resident was tolerating the feeding that she reviewed, or the nurses informed her. She further stated that they discussed it during the morning meeting. The RD

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F 658	Continued From page 14 stated that she did not believe there were physical orders and that it was "just a standard of practices for the nurses." The RD stated that the water flushes were an order as she wrote the orders for the formula and the water flushes which were for additional fluids to ensure the residents were meeting their hydration needs which was typical 250 mL every six hours. The RD stated that the nursing generally entered the orders for the flushes before and after medications. She stated that it would 30 mL before and after medications. She explained she just addressed the formula rate, the resident's calorie, and fluid needs. The RD stated that to her knowledge if the residual was over 200 mL, the nurses held the feeding for at least four hours, and if over 300 mL, the feeding would be stopped and the physician would be notified. The RD concluded there was no formal order as for the checking the residual. On 6/28/23 at 10:25 AM, the surveyor interviewed LPN #2 who stated the process for the FT included checking the placement, checking the residual, but she was unsure of the amount for residual. She further stated that the nurses flushed the FT with 30 mL before and after medication administration and five (5) mL between each medication. She stated that it was rare that they had residents with FT. She further stated they were educated on when Resident #778 arrived to ensure everyone remembered the appropriate steps. The surveyor asked did they need a physician's order to ensure accountability, and LPN #2 replied they needed an order to document for checking the placement, the residual, and the water flushes. LPN #2 stated that it was important to have	F 658		

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F 658	Continued From page 15 physician's orders because sometimes "things could be overlooked if there is no order and you can forget because being on the floor can be crazy and having the order is necessary as it shows accountability of what we did." She stated she had Resident # 778 three times, and she documented in the Medication Administration Record (MAR) and the Treatment Administration Record (TAR) for checking of the placement and the water flushes, but was unsure of the residual. She stated that with her experience any residual over [redacted] mL, she would inform the physician. She further stated that if she was unsure of the residual amount and the steps, she would just ask questions, but that was just her. On 6/28/23 at 11:09 AM, the surveyor asked the DON about the monitoring of the residual that was listed on the resident's care plan. The DON in the presence of the survey team stated that anything over [redacted] mL, she would hold the feeding and call the physician. She then stated that was a low amount [redacted] mL], and she would have to review to confirm. The surveyor asked if there was no order on when to hold the feeding, and multiple staff members gave different answers, how would you know when to hold the feeding and notify the physician? The DON stated that she did not have an answer. The DON acknowledged that there was no way to ensure accountability if there was no PO. On 6/30/23 at 9:36 AM, the LNHA in the presence of the DON, and the survey team stated that there should be an order for when to hold and notify the physician on a certain amount of residual. The LNHA acknowledged there should be orders for accountability.	F 658		

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F 658	Continued From page 16 On 6/30/23 at 10:32 AM, the LNHA provided a copy of the "Adult Gastric Residual Monitoring" which she stated it was what the RD provided to staff when they had residents on a tube feeding. She stated that she did not believe this was listed in their policy for guidance. A review of the facility provided "Adult Gastric Residual Monitoring" form undated included, measure gastric residual volumes (GRV) use at least a 60 mL syringe. For continuous pump feedings check every six (6) hours. If GRV< [less than] 200 mL re-instill gastric residual contents and continue with feeding. If the GRV was > (greater than) 200 mL, re-instill gastric residual contents and hold the feedings for one (1) hour than recheck. If residual > (greater than) 300 after rechecking hold the feeding and contact the medical doctor. A review of the facility provided in-service Tube Feeding Update from 5/22/23 to 5/29/23, included review of the enteral feeding connector and basic feeding tube procedures. In addition, it reflected per the [company's name redacted] Nursing Procedures Manual to verify tube placement, aspirate (to draw) contents from the tube with an enteral syringe, flush the enteral tube with 30 mL of water before and after feedings if ordered, assess every four hours for gastrointestinal intolerance by assessing abdominal distention, monitoring for complaints of abdominal pain, do not monitor gastric residual volume routinely. A further review did not include water flushes before and after medications. A review of the facility's "Policy Enteral Nutrition"	F 658		

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F 658	Continued From page 17 dated reviewed 8/08/22, included...3. The dietician will input from the provider and nurse d. calculates fluid to be provided (beyond the free fluids in formula...11. The nurse confirms that orders for enteral nutrition are complete. Complete orders include f. instructions for flushing (solution, volume, frequency, timing and 24-hour volume). 12. The provider will consider the need for supplement orders, including: a. confirmation of tube placement and g. checks for gastric residual volume (GRV). It further revealed for procedure, to refer to the [company's name redacted] Nursing Procedure Book... A review of the "Medication Orders - Receiving and Recording" policy date reviewed 1/10/23, included...4. Enteral Orders - when recording orders for tube feedings, specify the type of feeding, amount, frequency of feeding and rationale if prn [as needed]. The order should always specify the amount of flush following the feeding... NJAC:8:39-11.2(b); 27.1(a); 29.2(d)	F 658		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by:	F 695		7/28/23

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F 695	Continued From page 18 Based on observations, interviews, and review of facility documentation, it was determined that the facility failed to a.) ensure respiratory equipment was kept in a clean and sanitary condition to prevent infection and ensure a portable oxygen tank was stored in accordance with facility policy and b.) develop an individualized care plan for the administration and treatment of oxygen. This deficient practice was identified for 1 of 1 residents reviewed for NJ Exec. Order 26:4.b.1 (Resident #66), and the evidence was as follows: According to the facility's Admission Record face sheet (an admission summary), Resident #66 was admitted to the facility with diagnoses that included but were not limited to EX Order 26.4B1 [redacted]. A review of a the most recent quarterly Minimum Data Set (MDS), an assessment tool, dated EX Order 26.4B1, revealed the resident had a brief interview for mental status (BIMS) score of EX Order 26.4B EX Order 26, which indicated that the resident's EX Order 26.4B1. A further review revealed the resident received EX Order 26.4B1. A review of the resident's Order Summary Report revealed an order dated EX Order 26.4B1 for continuous EX Order 26.4B1 at EX Order 26.4B1 EX Order 26.4B1 (NJ Exec. Order 26:4.b.1 check NJ Exec. Order 26:4.b.1 every shift.	F 695	PREFIX TAG F695; 483.25(i); Respiratory/Tracheostomy Care and Suctioning Criteria #1 Masonic Village of Burlington's priority is the safety and care of our residents. During our Annual Re-Certification survey, one NJ Exec. Order 26:4.b.1 was found in a resident's room in an NJ Exec. Order 26:4. carry bag resting on the floor with the NJ Exec. Order 26:4 for the NJ Exec. Order 26:4 touching the floor. A review of this resident's medical record showed that the use and care of NJ Exec. Order 26:4 for this resident was not found in the Comprehensive Care Plan. When brought to our attention, the NJ Exec. Orde was immediately removed from the resident's room and the NJ Exec. Order 26 was discarded. The resident continued to use NJ Exec. Order 26:4 via the NJ Exec. Order 26:4.b.1 which also was in the room with the NJ Exec. Order 26:4 correctly labeled and secured. This resident's Comprehensive Care Plan was updated to include delivery of NJ Exec. Order 26:4.b.1. Criteria #2 Because all residents have the potential to be affected by this citation, the care plan for all residents receiving oxygen therapy was reviewed to ensure that oxygen delivery was included on their care plans. All were found to be compliant. In addition, the rooms of all the residents receiving oxygen therapy were checked and no free-standing oxygen cylinders were found. All oxygen tubing connected to concentrators were	

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F 695	Continued From page 19 A review of Resident #66's corresponding June 2023 Treatment Administration Record (TAR) included the above physician's order and was documented as administered. A review of Resident #66's individualized comprehensive care plan (ICCP) did not include [NJ Exec. Order 26:4.b.1] and usage. On 6/21/23 at 9:50 AM, during the initial tour of the [EX Order 26.4B1] Unit, the surveyor observed a portable [NJ Exec. Order 26:4.b.1] in a black bag hanging from the wheelchair in Resident #66's room. The undated [NJ Exec. Order 26:4.b.1] was observed connected to the tank and the [NJ Exec. O] was observed resting on the floor. On 6/22/23 at 9:19 AM, in Resident #66's room, the surveyor observed a portable [NJ Exec. Order 26:4.b.1] in a black bag resting on the floor in front of the wheelchair. The undated [NJ Exec. Order 26:4.b.1] was connected to the tank and the [NJ Exec. O] was resting on the floor. On 6/26/23 at 11:15 AM, in Resident #66's room, the surveyor observed a portable [NJ Exec. Order 26:4.b.1] in a black bag resting on the floor in front of the wheelchair. The undated [NJ Exec. Order 26:4.b.1] was connected to the tank and was rolled up and hung on top of the tank. The resident acknowledged that it was the tank that he/she used when they left the facility for their appointment on 6/23/23 and stated, "The bag slips over the handle of the wheelchair." 1. On 6/26/23 at 11:40 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) caring for Resident #66 who stated that the	F 695	labelled and secured appropriately. Criteria #3 To enhance currently compliant operations and under the Director of Nursing all team members will receive in-service training reviewing our policy on the proper storage and maintenance of oxygen tanks and tubing as well as the need to ensure all respiratory therapy initiatives are care planned. Criteria #4 Our QAPI plan was revised under the direction of the Administrator to monitor compliance with the policy for proper storage and handling of oxygen equipment and the subsequent documentation of such. The Director of Nursing/Designee will audit all rooms with resident's who have orders for oxygen therapy each week for 4 weeks to ensure all are stored and labelled appropriately and that the care plans reflect the use of oxygen. Any deficiencies noted will be brought to the attention of the appropriate Manager/Supervisor and staff member. Results of the observations will be reviewed at our monthly QAPI meeting.	

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resident was ordered NJ Exec. Order 26:4.b.1 , and that when he/she left the building that they NJ Exec. Order 26:4.b.1 that hung in a black bag off the back of the wheelchair. Together, the surveyor and the LPN observed a NJ Exec. Order 26:4.b.1 on the floor in the resident's room and the LPN acknowledged that it was the NJ Exec. Ord that the resident had left the facility with on 6/23/23. The LPN stated the NJ Exec. Ord should not have been resting on the floor, and that she was unsure how old the NJ Exec. Order 26:4.b.1 was because it was not dated. The LPN stated it was important to keep the equipment off the floor to keep it as clean as possible because it could have gotten dust, dirt, or germs on it. She then removed the NJ Exec. Order 26:4.b.1 from the room.

On 6/26/23 at 12:26 PM, the surveyor interviewed the Neighborhood Manager (NM) who stated that NJ Exec. Order 26:4.b.1 was dated and changed weekly and that portable NJ Exec. Order 26:4.b.1 were stored in an NJ Exec. Order 26:4 closet in a stand. The surveyor informed the NM of Resident #66's portable NJ Exec. Order 26:4.b.1 observations. The NM acknowledged that the portable NJ Exec. Order 26:4.b.1 should not have been stored on the ground in a resident's room and that it was important for infection control to keep the NJ Exec. Order 26:4.b.1 off the ground.

On 6/26/23 at 12:40 PM, the surveyor interviewed the Director of Nursing (DON) who stated that portable NJ Exec. Order 26:4.b.1 were kept in a storage closet on each unit and that once a NJ Exec. Orde was used, that it would be replaced to the closet. The surveyor informed the DON of Resident #66's portable NJ Exec. Order 26:4.b.1 observations. The DON acknowledged that there should not have

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F 695	Continued From page 21 been an unused portable [NJ Exec. Order 26:4.b.1] left in a resident's room. The DON stated that for safety purposes, the [NJ Exec. Order 26:4.b.1] should have been secured and that for infection control, the [NJ Exec. Order 26:4.b.1] should have been dated and should not have been resting on the floor. 2. On 6/27/23 at 12:12 PM, the surveyor interviewed the Registered Nurse (RN) caring for Resident #66. The RN stated that an ICCP was put together for each resident with their diagnosis, plans for care, assessments and evaluations and that the nurse was able to add or update the ICCP at any time. The RN acknowledged that she would expect to see oxygen on an ICCP, and that it was important to include on the ICCP how many [NJ Exec. Order 26:4.b.1] were ordered and any [NJ Exec. Order 26:4.b.1] for the resident in case of [NJ Exec. Order 26:4.b.1]. In the surveyor's presence, the RN reviewed Resident #66's ICCP and stated she did not see [NJ Exec. Order 26:4.b.1] listed. On 6/27/23 at 12:20 PM, the surveyor interviewed the NM who stated that an ICCP was a resource used to provide the desired care and a picture of the resident's needs. He stated that it was created and updated by the interdisciplinary team and that every discipline was able to update it. The NM stated that he would have expected to see a [NJ Exec. Order 26:4.b.1] ICCP that mentioned [NJ Exec. Order 26:4.b.1]y or an actual order that the resident was on [NJ Exec. Order 26:4.b.1]. The NM acknowledged that Resident #66 [NJ Exec. Order 26:4.b.1] In the surveyor's presence, the NM reviewed Resident #66's ICCP and stated he did not see [NJ Exec. Order 26:4.b.1] listed, and that [NJ Exec. Order 26:4.b.1] should have been on the ICCP. He further stated that it	F 695		

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was important to include [NJ Exec. Order 26:4.b] on the ICCP so that everyone could have made sure the resident was provided appropriate care.

On 6/27/23 at 12:26 PM, the surveyor interviewed the DON who stated that an ICCP listed the care that the resident required and that the nurse should have been familiar with each resident's ICCP and should have reviewed the ICCP for any updates. The DON stated that if a resident was on [NJ Exec. Order 26:4.b] n, that she would have expected to see [NJ Exec. Order 26:4.] on the ICCP. In the surveyor's presence, the DON reviewed Resident #66's ICCP and acknowledged she it did not include [NJ Exec. Order 26:4.b], and that [NJ Exec. Order 26:4.b] should have been included. She further stated that it was important for [NJ Exec. Order 26:4.] to be on the ICCP so that everyone would have known what the plan was for the resident's [NJ Exec. Order 26:4.b.1].

On 6/28/23 at 11:09 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) who stated that oxygen tanks were stored in the oxygen closets and that if a resident needed portable oxygen, that the nurse retrieved a portable tank from the closet and placed it in a sling bag on the resident's wheelchair, or may use the rollator (metal bracket on wheels that holds the portable oxygen tank). The LNHA stated the portable oxygen tanks should not have been stored in resident's rooms, the tanks should have always been in a holder off the floor and the NC tubing should not have been resting on the floor. The surveyor informed the LNHA of Resident #66's portable [NJ Exec. Order 26:4.b.1] observations. The LNHA acknowledged that the portable oxygen tank should not have been stored on the floor in the resident's room and that

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F 695	Continued From page 23 it should have been in the [NJ Exec. Order 26:4.b.1], and that the [NJ Exec. Order 26:4.b.1] should have been dated and secured in a plastic bag. During the same interview, the LNHA stated that an ICCP was a plan of care provided to each resident while at the facility. She stated that the ICCP was completed by the interdisciplinary care team, that everyone contributed based on the needs of the resident, and that it was used by all clinical team members. The LNHA stated that if a resident was ordered continuous oxygen, that she would have expected to see oxygen on the ICCP. She further stated that it was important for oxygen to be included on the ICCP so that the team was made aware that the resident was on oxygen, any breathing issues would have been monitored, it would have been used to confirm the correct amount of oxygen was being administered, and that if the resident were to go out to an appointment that they would have been aware that the resident would have needed continuous oxygen. A review of facility's "Oxygen," policy dated revised 8/6/22, included A. Storage, Oxygen is to be kept in designated areas on the nursing units except when in use... 2. Portable O2 (oxygen) tanks will be available and secured in a rack...C. Safety...2. Oxygen must be kept in a stand or cart... D. Method of Delivery, O2 will be administered via nasal cannula unless otherwise specified by physician order. Nasal cannula to be changed weekly and PRN (as needed)... A review of facility's "Care Planning," policy dated revised 8/1/21, included...I. Procedure...B. The comprehensive care plan is based on a thorough	F 695		

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 06/30/2023

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F 695	Continued From page 24 assessment that includes, but is not limited to, the MDS. C. Each resident's comprehensive care plan is designed to: a. Incorporate identified problem areas; b. Incorporate risk factors associated with identified problems...e. Reflect treatment goals, timetables and objectives in measurable outcomes...g. Aid in preventing or reducing declines in the resident's functional status and/or functional levels... E...the care plan outlines those individualized interventions to specifically address the resident's issues...	F 695		
F 761 SS=D	NJAC 8:39-11.2(e), 27.1(a) Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug	F 761		7/28/23

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F 761	Continued From page 25 Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to appropriately label and date two Tubersol (tuberculin purified protein derivative [PPD]; a clear, colorless solution injected into the skin of the forearm that aides in the detection of tuberculosis). This deficient practice was identified in 1 of 2 medication storage rooms inspected in the facility (Magnolia nursing unit), and was evidenced by the following: On 6/21/23 at 11:30 AM, the surveyor inspected the medication storage room by the Magnolia nursing unit in the presence of the Registered Nurse (RN). At that time, the surveyor observed two opened and undated Tubersol solutions in the refrigerator. On 6/21/23 at 11:34 AM, the surveyor interviewed the RN who stated that the Tubersol was to be dated when it was opened. The RN then told the surveyor that she was not sure if the Tubersol was supposed to be dated upon opening, and wanted to ask another staff member. The RN then exited the medication storage room. On 6/21/23 at 11:36 AM, the RN re-entered the medication storage room and informed the surveyor that her Unit Manager/Registered Nurse (UM/RN) told her the medication was supposed	F 761	PREFIX TAG F761; 483.45(g)(h)(1)(2) Criteria #1 Masonic Village of Burlington's priority is the safety and care of our residents. During our Annual Re-Certification survey, 2 vials of Tubersol,(tuberculin purified protein derivative),(PPD), were found in one of our medication rooms open, but not labeled with the date on which they were opened. When brought to our attention, the vials were immediately discarded. Criteria #2 Because all residents have the potential to be affected by this citation, all open medication vials were checked in all med storage areas and all were found to be properly labelled. Criteria #3 To enhance currently compliant operations and under the Director of Nursing all nursing staff will receive in-service training reviewing our policy on the proper labelling of medication vials once opened. Criteria #4 Our QAPI plan was revised under the	

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F 761	Continued From page 26 to be dated upon opening. On 6/21/23 at 11:39 AM, the surveyor interviewed the UM/RN who confirmed the Tubersol should have been dated upon opening and stored in the refrigerator. The UM/RN further stated that it was important to date the medication, "for expiration purposes". On 6/23/23 at 11:43 AM, the surveyor conducted an interview over the telephone with the facility's Consultant Pharmacist (CP) who stated that upon opening the medication Tubsersol, the medication was required to be dated. The CP explained after the medication was opened, it was only good for usage for 28 - 30 days per the manufacturer' specifications for usage. On 6/23/23 at 12:36 PM, the surveyor interviewed the Director of Nursing (DON) who stated that the Tubsersol needed to be dated upon opening because the medication was only good for 30 days. The DON acknowledged it was important to date the medication, so the nursing staff knew when the medication was going to expire. A review of the undated Tubsersol package insert from the Food and Drug Administration included...A vial of Tubersol which has been entered and in use for 30 days should be discarded... A review of facility's pharmacy, "Medication Storage Guidelines" dated 2022, included Tubersol was required to be dated upon opening and the unused portion was to be discarded after 30 days...	F 761	direction of the Administrator to monitor compliance with the policy for the proper handling of open medication vials. The Director of Nursing/Designee will audit all medication rooms twice a week for four weeks to ensure that we are 100% compliant with this policy. Any deficient practice will be noted and brought to the attention of the appropriate Manager/Supervisor and staff member. Results of the observations will be reviewed at our monthly QAPI meeting.	

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F 761	Continued From page 27 A review of the facility's, "Medication Storage Policy" dated 10/6/22, included...medications were labeled accordingly... NJAC 8:39-29.6(b)1	F 761		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
315166		8/15/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MASONIC VILLAGE AT BURLINGTON	902 JACKSONVILLE ROAD BURLINGTON, NJ 08016

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, 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 CMS-2567 (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 F0658 Reg. # 483.21(b)(3)(i) LSC	Correction Completed 07/28/2023	ID Prefix F0695 Reg. # 483.25(i) LSC	Correction Completed 07/28/2023	ID Prefix F0761 Reg. # 483.45(g)(h)(1)(2) LSC	Correction Completed 07/28/2023
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
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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	
6/30/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315166	A. BUILDING **01** B. WING _____	**06/30/2023**

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K 000	INITIAL COMMENTS The nursing home building construction was stated to be 1970s with no current major renovations or noted additions. It is a three-story building Type II (222) protected construction and is fully sprinklered. There is supervised smoke detection located in the corridors, spaces open to the corridors and in resident rooms. The generator outside the facility is stated to be tied to the fire alarm control panel, electric fire pump, cross corridor door hold open devices, exterior door releases, emergency facility lighting and life safety components utilized for preservation of life. The facility has 6-smoke zones, 2-diesel generator's that do approximately 60% of the building, and 1-electric fire pump. Floor #3 skilled nursing unit consists of: Magnolia unit, Lilac Lane, Pleasant Vally (Cindy Springs) and Blue (New Hope rehab area). Independant living apartments were not observed. Currently cosmetic upgrades are being completed to the closed 1st floor wing: resident rooms 132 to 160 known as North Cape May, located on the first floor in the North Building. The 24-hour security team does the daily inspection of the means of egress in areas of construction, repair, alterations or additions. When completed the first floor wing will be short-term rehabilitation services (skilled nursing setting), the solarium area will be used for occupational therapy. The facility has 264 certified beds. At the time of the survey the census was 84.	K 000		

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

Electronically Signed | 07/20/2023

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K 000	Continued From page 1 The requirement at 42 CFR Subpart 483.90(a) is NOT MET as evidenced by:	K 000		
K 291 SS=F	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 6/26/23, in the presence of the Maintenance Director (MD), it was determined that the facility failed to provide a battery backup emergency light above the three transfer switches (2-generator and 1-fire pump) independent of the building's electrical system and emergency generator, in accordance with NFPA 101:2012 - 19.2.9.1.- 7.9.1 (general) This deficient practice was identified for 2 of 2 transfer switches and was evidenced by the following: 1. On 6/26/23 at 11:05 AM, the surveyor, in the presence of the MD, observed one (1) generator transfer switch, ATS-1, inside the main electrical room in the basement. The room was not provided with any independent emergency lighting. 2. On 6/26/23 at 11:10 AM, the surveyor, in the presence of the MD, observed one (1) generator transfer switch, ATS-2, inside the interior of the small generator room in the basement. The room was not provided with any independent emergency lighting. 3. On 6/26/23 at 12:14 PM, the surveyor, in the	K 291	PREFIX TAG K291; 8:39-31.2(e); NFPA 101:2012-19.2.9.1, 7.9 Criteria #1 Masonic Village□s priority is the safety and welfare of all our residents. It is a requirement that nursing homes have automatic emergency lighting that lasts at least 90 minute duration in accordance with 7.9.18.2.9.1, 19.2.9.1 During the survey, it was determined that Masonic Village failed to provide battery backup emergency light above three transfer switches (2- generator and 1- fire pump) that are independent of the building's electrical system and the emergency generator in accordance with NFPA 101:2012-19.2.9.1-7.9.1. Immediately after being brought to our attention, the Facilities Director contacted our Electrical Contractor who corrected the identified issues on 7/12/2023. Criteria #2 Because all residents, staff, and visitors have the potential to be affected by this citation, all other maintenance rooms in	7/28/23

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K 291	Continued From page 2 presence of the MD, observed one (1) electric fire pump transfer switch in the basement fire sprinkler room, was not provided with any independent emergency lighting. The MD confirmed the findings at the time of the observations. The Licensed Nursing Home Administrator was informed of the findings at the Life Safety Code exit on 6/26/23. NJAC 8:39-31.2(e) NFPA 101:2012 - 19.2.9.1, 7.9	K 291	the community were inspected and all were found to comply. Criteria #3 To enhance currently compliant operations and under the direction of the Director of Facility Services, all maintenance team members will be inserviced by the Director of Facility Services regarding the emergency lighting requirements and required testing. In addition, testing of independent emergency lighting will occur monthly and a full test of 90 minutes duration will occur yearly. Criteria #4 Our QAPI plan was revised under the direction of the Administrator to monitor compliance with ensuring that automatic emergency lighting functions as expected, lasting the minimum of 90 minutes. The Director of Facility Services/Designee will test all independent emergency lighting monthly with a full test of 90 minutes duration annually. Results of the observations will be reviewed at our monthly QAPI meeting.	
K 331 SS=F	Interior Wall and Ceiling Finish CFR(s): NFPA 101 Interior Wall and Ceiling Finish 2012 EXISTING Interior wall and ceiling finishes, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and have a flame spread rating of Class A or Class B. The reduction in class of interior finish for a	K 331		7/28/23

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K 331	Continued From page 3 sprinkler system as prescribed in 10.2.8.1 is permitted. 10.2, 19.3.3.1, 19.3.3.2 Indicate flame spread rating(s). _____ This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, in the presence of the Maintenance Director (MD), it was determined that the facility failed to ensure that interior wall finishes were either a Class A and/or Class B in egress corridors, or a Class C rating within a room. This deficient practice was evidenced for 3 of 4 wings in the exit/egress corridors of the third floor and was evidenced by the following: On 6/26/23 from approximately 9:30 AM to 1:30 PM, the surveyor observed on the third floor, that carpet was installed on the lower two-foot (2') section of the walls in exit corridors of the: Magnolia wing Lilac Lane (skilled nursing) Blue New Hope rehabilitation area (Skilled Nursing) The carpet measured approximately 24 inches up from the floor. The MD was asked to provide documentation on the flame spread and smoke development testing of the carpet used on the vertical surface. He stated that currently he could not produce any documentation as the carpet was installed prior to his employment many years ago. The carpet was observed to have stains in areas of the alcohol-based hand rub dispenser (ABHR) locations.	K 331	PREFIX TAG K331; 8:39-31.2(e),(c); NFPA 101:2012-10.2.3*. 10.2.8.1; 19.3.3 Interior Finish; General 19.3.3.2* Interior Wall Finish Criteria #1 It is a requirement that interior wall and ceiling finishes, including exposed interior surfaces of buildings such as fixed or moveable walls, partitions, and columns have a flame spread rating of Class A or Class B and indicate flame spread ratings. On survey, Masonic Village could not produce documentation of flame spread rating of carpeted wall finishes which had been in place over 20 years. Immediately after being brought to our attention our Facilities Director contacted our contractor, Custom Wallpapering and Painting. Work began to remove the existing carpet wall coverings on Monday, July 17th and will be completed by end of day on Friday, July 21, 2023. Criteria #2 Because all residents have the potential to be affected by this citation, all areas in our skilled nursing community were inspected to ensure all areas with carpet on walls were identified and removed.	

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K 331	Continued From page 4 The Licensed Nursing Home Administrator was informed of the findings at the Life Safety Code exit on 6/26/23. No further information was provided. N.J.A.C. 8:39-31.2(e) N.J.A.C. 8:39-31.1(c) NJAC 101 2012 edition Life Safety Code 10.2.3* and 10.2.8.1 19.3.3 Interior Finish 19.3.3.1 General 19.3.3.2* interior wall finish	K 331	Criteria #3 To enhance currently compliant operations and under the direction of the Director of Facility Services, all maintenance team members will be re-inserviced by the Director of Facility Services regarding all interior wall and ceiling finish requirements, including exposed interior surfaces of buildings such as fixed or moveable walls, partitions, and columns have a flame spread rating of Class A or Class B, and indicate flame spread ratings. Criteria #4 Our QAPI plan was revised under the direction of the Administrator to monitor compliance with ensuring that all wall coverings meet the requirements of 8:39-31.2(e),(c); NFPA 101:2012-10.2.3*. 10.2.8.1; 19.3.3 Interior Finish; General 19.3.3.2* Interior Wall Finish. The Director of Facility Services/Designee will report any changes in wall finishes at each QAPI meeting and indicate that all are compliant.	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72	K 345		7/28/23

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K 345	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review on 6/23/23 and 6/26/23, in the presence of the Maintenance Director, it was determined that the facility failed to ensure that their building's fire alarm system was maintained in accordance with the requirements of NFPA 70 and 72. This deficient practice had the potential to affect all residents in the facility and was evidenced by the findings below: 1. On 6/23/23, the surveyor observed that the main fire alarm panel located in the security office, was in trouble mode. 2. On 6/26/23, the surveyor observed that the main fire alarm panel located in the security office, was in trouble mode. The annunciator panel indicated: (1). 0001 local trouble act 110000608Auxiliary port two (2). 0011 local trouble act 02020672MAP fault DataCard 1 A000 S000 To11 M000 The trouble amber light was lit The Panel/ Silence light was lit On 6/26/23 at 10:10 AM, the Maintenance Director provided a document from the fire alarm vendor dated 6/26/23. The document indicated the existing troubles on the panel were a couple	K 345	PREFIX TAG K345; 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Criteria #1 Masonic Village□s priority is the safety and welfare of all our residents. During our reinspection survey, the main fire alarm panel located in the security office was noted to be in trouble mode. The Director of Facility Services contacted our vendor who provided documentation to indicate that the existing troubles on the panel were a couple of ground faults and a telephone line 1 trouble. The fire alarm vendor scheduled service to trace out the ground faults. The fire panel always remained operational and could send signals to the central station as well as notify the occupants of the building despite the trouble light being illuminated. Criteria #2 Because all residents, staff, and visitors have the potential to be affected by this citation, all aspects of our fire suppression system was assessed and found to be functional without indication of trouble or errors. Criteria #3 To enhance currently compliant operations and under the direction of the Director of Facility Services, all maintenance team members will be inserviced by the Director of Facility Services regarding the need to monitor	

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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
K 345	Continued From page 6 ground faults and a telephone line 1 trouble. The fire alarm vendor will schedule a service to trace out the ground faults. The fire panel is operational and will send signals to the central station as well as notify the occupants of the building. The Maintenance Director on 6/23/23 at 11:14 AM, indicated that the trouble on the fire alarm system annunciator panel was due to the renovation on the first-floor North Cape May project. The Licensed Nursing Home Administrator was informed of the findings at the Life Safety Code Exit Conference on 6/26/23. NFPA 70 NFPA 72 NJAC 8:39-31.2(e) NFPA 101- 2012 edition 9.6.1.3- 9.6.1.5	K 345	the alarm panels and to report any irregularities immediately. Criteria #4 Our QAPI plan was revised under the direction of the Administrator the Director of Facility Services/Designee will monitor compliance with reporting any alerts immediately by checking the panels twice a week for 4 weeks to ensure that there are no alarms noted. Results of the observations will be reviewed at our monthly QAPI meeting.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315166	A. Building 01 - MAIN BUILDING 01 B. Wing	8/15/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MASONIC VILLAGE AT BURLINGTON	902 JACKSONVILLE ROAD BURLINGTON, NJ 08016

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, 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 CMS-2567 (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 Reg. # NFPA 101 LSC K0291	Correction Completed 07/28/2023	ID Prefix Reg. # NFPA 101 LSC K0331	Correction Completed 07/28/2023	ID Prefix Reg. # NFPA 101 LSC K0345	Correction Completed 07/28/2023
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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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 6/30/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			