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 03/28/2025

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	F 000		

Complaint #s: NJ 174543, NJ 174805, NJ 179076

Survey Date: 3/21/25 through 3/28/25

Census: 113

Sample: 25 + 1 Closed Record

A Recertification/LSC survey was conducted at Masonic Village at Burlington from 3/21/25 through 3/28/25, to determine compliance with 43 CFR Part 483 requirements for Long Term Care Facilities.

1. During the survey, a finding which constituted an Immediate Jeopardy (IJ) was identified under 42 CFR Part 483.12(a)(1) F 600 and F 610 as the facility to ensure that all residents were [redacted] from [redacted] including NJ Exec Order 26.4b1, and [redacted] were thoroughly investigated to rule out [redacted]

Resident #51, who was NJ Exec Order 26.4b1, had a NJ Exec Order 26.4b1 that required several NJ Exec Order 26.4b1) that the Certified Nurse Aide (CNA #1) reported on [redacted], to the Licensed Practical Nurse (LPN #1), that the resident [redacted] themself. LPN #1 documented that the resident also had a [redacted] by NJ Exec Order 26.4b1. LPN #1 did not notify the US FOIA (b)(6) that day, and on [redacted] when the facility reviewed video footage of the incident, the facility discovered that CNA #1 NJ Exec Order 26.4b1 Resident #51. At that time, two days later, CNA #1 was suspended and an investigation was started. During the video

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

Electronically Signed | 04/21/2025

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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observation of the incident on [redacted], Resident #36, a NJ Exec Order 26.4b1 resident, was identified sitting at the table next to Resident #51 witnessing the [redacted] An interview with the US FOIA (b)(6) [redacted]) on [redacted], revealed that the facility did not assess Resident #36 who witnessed the event for NJ Exec Order 26.4b1 [redacted] and the facility did not assess any other residents to determine if they were [redacted]

The Administration were informed of the F 600 and F 610 IJs, and were provided the IJ templates on 3/25/24 at 2:54 PM.

Acceptable Removal Plans were received on 3/27/25 at 2:22 PM, indicating the action the facility will take to prevent serious harm from occurring or recurring. The facility implemented a corrective action plan to remediate the deficient practice including; on 3/27/25 Resident #51 and Resident #36 were assessed by the US FOIA (b)(6) [redacted] to confirm NJ Exec Order 26.4b1 or NJ Exec Order 26.4b1 related to the [redacted] incident, all nurse managers and supervisors would be required to respond to all reported incidents and accidents, the Abuse Policy was amended to include any staff involved with an [redacted] to a resident must be removed immediately from resident contact and all residents that had contacted with the [redacted] be assessed and/or interviewed to ensure no [redacted] or NJ Exec Order 26.4b1 [redacted] had occurred, staff involved with any incident or NJ Exec Order 26.4b1 [redacted] must remove the involved staff member immediately and that person must leave the clinical area and not have further contact with residents until the investigation is completed, all other residents who

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are on the NJ Exec Order 26.4b1 assignment or have contact with the NJ Exec Order 26.4b1 be assessed and/or interviewed to ensure no NJ Exec Order 26.4b1 exist, and a Supervisor or Manager must respond to all accidents and incidents in person to determine if the NJ Exec Order 26.4b1 and the Supervisor/Manager must call the US FOIA (b)(6) for all cases of NJ Exec Order 26.4b1 origin.

The Removal Plan was verified by the survey team on-site on 3/28/25 at 9:20 AM, during the continuation of the on-site survey.

2. During the survey, a finding which constituted an IJ was identified under 42 CFR 483.60 F 808 as the facility failed to ensure NJ Exec Order 26 orders and special instructions for "NJ Exec Order 26.4b1" were adhered to ensure a resident who was at risk for NJ Exec Order 26.4 and was on NJ Exec Order 26.4b1 precautions.

On 3/25/25 at 8:30 AM, the surveyor observed a NJ Exec Order 26.4b1 resident, Resident #3, in the NJ Exec Order 26.4b1 who was consuming their meal. The resident began to NJ Exec Order 26.4b1. The surveyor observed a plastic cup that was half filled with liquid (NJ Exec Order 26.4b1) and a NJ Exec Orde was inserted through the lid. At that time, the US FOIA (b)(6) proceeded to the resident and removed the NJ Ex Order 2 from the lid and informed the US FOIA (b)(6) the resident could not have a NJ Exec Order An interview 3/25/25, with the US FOIA (b)(6) revealed that Resident #3 had NJ Exec Order 26.4b1 and NJ Exec Order 2 had been discontinued because the resident NJ Exec Order 26.4b1 ."

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F 000	Continued From page 3 The Administration were informed of the F 808 IJ, and were provided the IJ templates on 3/25/24 at 2:54 PM. The acceptable Removal Plan on 3/27/25 at 11:31 AM, indicated the action the facility will take to prevent serious harm from occurring or reoccurring. The facility implemented a corrective action plan to remediate the deficient practice which included; on 3/25/25 at 8:30 AM, LPN #1 immediately removed the [NJ Exec Orde] from Resident #3's cup and explained to CNA #1 the resident's special [NJ Exec Order 26] instructions, the nurse [NJ Exec Order 26.4b1] ([NJ Exec Order 26.4b1] for Resident #3 and their [NJ Exec Order 26.4b1]; on [NJ Exec Order 26.] at 8:17 PM, the [US FOIA (b)(6)] assessed the resident, Resident #3 was ordered a [NJ Exec Order 26.4b1] to rule out [NJ Exec Order 26.4b1] and vitals were ordered every shift for three days to monitor for signs and symptoms of [NJ Exec Order 26.4b1] all nursing and dining staff were educated on the facility's policy for checking the meal ticket against what was being served to our residents with emphasis placed on the need to look at any printed special instructions. The Removal Plan was verified by the survey team on-site on 3/28/25 at 9:20 AM, during the continuation of the on-site survey.	F 000		
F 600 SS=K	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from	F 600		4/21/25

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F 600	Continued From page 4 corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Complaint #: NJ 174085 Refer to F 610 Based on observation, interviews, record review, and review of pertinent documentation, it was determined that the facility failed to protect a NJ Exec Order 26.4b1 resident from NJ Exec Order 26.4b1 and ensure all other residents were protected from potential NJ Exec Order 26 This deficient practice occurred for 1 of 2 residents reviewed for NJ Exec Order 2 (Resident #51). A review of an NJ Exec Order 2 investigation revealed on NJ Exec Order 26.4 at 9:45 PM, on the NJ Exec Order 26.4b1 Unit, a Licensed Practical Nurse (LPN #1) was informed by a Certified Nurse Aide (CNA #1) that a NJ Exec Order 26.4b1 (Resident #51) had a NJ Exec Order 26.4b1 that required NJ Exec Order 26.4b1) from the resident (Resident #51) NJ Exec Order 26.4b1 themself and had a NJ Exec Order 26.4b1 NJ Exec Order 26.4b1. Observation of video footage from the time of the incident revealed that on NJ Exec Order 26.4, CNA #1 was observed NJ Exec Order 26 Resident #51 in their wheelchair to prevent the resident from NJ Exec Order 26.4b and NJ Exec Order 26.4 the resident's wheelchair from moving with a	F 600	Criteria #1 During our annual Department of Health re-certification survey, surveyors investigated an event that our community had self-reported on NJ Ex Order 26.4(b)(1), involving NJ Exec Order 26.4b1 of one of our residents by a staff Certified Nursing Assistant. The Certified Nursing Assistant was placed on NJ Exec Order 26.4b1 immediately following observation of confirmed NJ Exec Order 26.4b1 of the resident observed on videotape from an incident NJ Exec Order 26.4b1. Surveyors determined that the Certified Nursing Assistant should have been NJ Exec Order 26.4b1 from our community at the time of the originally alleged event. Certified Nursing Assistant employment was NJ Exec Order 26.4b1 on NJ Exec Order 26.4b1 Resident # 51 was evaluated by provider on NJ Exec Order 26.4b1 incident, NJ Exec Order 26.4b1 and NJ Exec O r. Resident #36 evaluated by provider for follow-up NJ Exec Order 26.4b1 On NJ Exec Order 26.4 resident #51 was seen by NJ Exec Order 26.4b1 NP. Criteria #2 Because all residents on our secured	

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F 600	Continued From page 5 chair and the CNA's body. The video footage identified a second resident, Resident #36, witnessed the incident and NJ Exec Order 26.4b1 themself away from the situation. Interview on NJ Exec Order 26.4b with the US FOIA (b)(6) revealed that the incident was not initially investigated as NJ Exec Order 2 until the former US FOIA (b)(6) reviewed the video footage two days later (NJ Exec Order 26.4) and identified that CNA #1 NJ Exec Order 26 Resident #51. The administration confirmed that CNA #1 finished working their shift on NJ Exec Order 26.4b and had access to all the residents on the NJ Exec Order 2 unit. Resident #36 was not assessed after the incident to rule out NJ Exec Order 26.4b1 NJ Exec Order The facility's failure to ensure all residents were NJ Exec Order 26.4b1 by not investigating the NJ Exec Order 26.4b1 or assessing Resident #36 who was present at the incident, posed a likelihood of NJ Exec Order 26.4b1 including NJ Exec Order 26.4b1 to Resident #36 and Resident #51. The facility's failure to immediately remove CNA #1 from resident care to protect all fourteen residents who resided on the NJ Exec Order 26.4b1 Unit posed the further risk of NJ Exec Order 2 for all residents with likelihood of serious NJ Exec Order [redacted]. This resulted in an Immediate Jeopardy (IJ) situation. The IJ situation began on NJ Exec Order 26.4b at 9:33 PM, when CNA #1 was observed NJ Exec Order 26 Resident #51 NJ Exec Order The facility's Administration were notified of the IJ on 3/25/25 at 2:54 PM. An acceptable Removal Plan (RP) was received on 3/27/25 at 2:22 PM. The RP was verified on-site by the survey team on 3/28/25 at 9:20 AM, during the continuation of the survey. The evidence was as follows:	F 600	dementia unit could be affected by this deficient practice, all present residents on that unit were assessed by the nursing team to ensure there were no injuries to any of the residents. No injuries were identified. Criteria #3 Under the direction of the Director of Nursing and in cooperation with the community Administrator, Our Abuse Policy was amended to reflect the following: 1. Staff involved with any incident or accident of unknown origin must remove the involved staff member immediately. That person must leave the clinical area and not have further contact with residents until the investigation is completed. 2. All other residents who are on the alleged perpetrator's assignment or has contact with the alleged perpetrator must be assessed and/or interviewed to ensure no physical or psychological injuries exist. 3. A Supervisor or Manager must respond to all accidents and incidents in person to determine if the injury origin is unknown. 4. The Supervisor/Manager must call the Administrator for all cases of injuries/accidents of unknown origin. 5. Any event which is unexplainable and suspicious in nature will be reported within 2 hours to the Department of Health. 6. A spreadsheet was developed to document all incidents and accidents. The spreadsheet will indicate who the Supervisor/Manager was who assessed	

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F 600	Continued From page 6 A review of the facility's policy in effect the date of the incident, "Abuse and Neglect", dated 5/4/23, included Policy: the [facility] will not permit residents to be subjected to any form of abuse/neglect...Abuse definition is the willful infliction of injury...intimidation,...mental anguish. Injuries of unknown source - classified...when both of the following conditions are met a.) source of the injury was not observed or the source could not be explained by the resident. AND b.) the injury is suspicious because of the extent, location,...Identification/Investigation/Protection: 1. The [facility] will identify all types of events including...bruising of residents...that may constitute abuse. 2...appropriate action will be taken to safeguard the resident from harm "while the incident is fully investigated." Actions to include...team member placed on fact finding leave pending investigation. Social Worker referral. Psychology consultation as appropriate. Response: all reported occurrences will be fully investigated...to determine what actions are necessary and what changes are needed to policies and procedures to prevent further occurrences. Abuse Training: to ensure proper training of new and existing team members on abuse/neglect prevention, identification and protection of residents. 6. Characteristics of the resident population at risk for abuse...cognitively impaired, psychological medical problems, communication disorders, those who require extensive nursing care. 7. Training on identifying suspicious bruising... A review of the facility's policy "Incident Reporting-Injuries of Unknown Origin/Source" dated revised 5/16/16, included Procedure: B. all injuries of unknown origin/source shall be	F 600	the situation, what they found to be any causal factors and whether or not they determined that the event was suspicious for abuse and if so if the appropriate next steps were taken. All nurses and Certified Nursing Assistants on duty were re-educated by education manager/designee on the revised Abuse and Neglect policy and thorough investigation post a new incident. No staff member was permitted to work until required training was complete. Education included contracted staff. Criteria #4 Our Quality Assurance and Performance Improvement plan was revised under the direction of the Administrator to monitor compliant practice with required documentation of such. We will review our spreadsheet of incidents/accidents daily for 3 months to ensure compliance with the above components of our Abuse policy. The results of the daily observations will be reviewed at our quarterly Quality Assurance and Performance Improvement meetings. The Quality Assurance and Performance Improvement committee will review outcomes and modify the plan as needed	

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investigated by the nurse on duty and/or Supervisor...E. the nurse will ask the resident how the injury occurred and document their answer. F. the nurse shall obtain statements from everyone on the shift...also from team members for 24 hours prior to the discovery of the injury. G. The nurse shall contact the Supervisor and notify them.

On 3/23/25 at 2:30 PM, the surveyor reviewed the Facility Reportable Event (FRE) submitted to the New Jersey Department of Health (NJDOH) by the former [redacted]) on [redacted], for Date/Time of Event: [redacted] at 9:35 PM. The location of the incident was the [redacted] and the type of incident was [redacted]. The Description of the Event included: CNA #1 stated she asked Resident #51 to [redacted] and she observed [Resident #51] [redacted] "As this is [redacted] for the resident" we requested camera footage of the [redacted] for that time period. The video was obtained today [redacted] and viewed by the [redacted]). The "video showed [CNA #1] [redacted] [Resident #51] from [redacted] with [redacted] [Resident #51's] [redacted] causing [Resident #51] to become [redacted]. [Resident #51] was attempting to [redacted] from [CNA #1] and [redacted] against [CNA #1]. [CNA #1] [redacted] [Resident #51's] [redacted] and [redacted] This is likely the cause of the [redacted] and [redacted] [Resident #51] showed [CNA #1] the [redacted] and [CNA #1] [redacted] [Resident #51's] [redacted] and [redacted] the resident out of the [redacted] to the nurse." Others notified: [name redacted] [redacted] Department after video review.

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A review of the "Incident Investigation" submitted with the FRE included: "[redacted]" Date: [redacted], and signed by the former [redacted] or [redacted] A statement summary from LPN #1 revealed ... [CNA #1] told her that she asked [Resident #51] to [redacted] and then observed [Resident #51] [redacted]. Investigational Findings:...[Resident #51] can [redacted] but had [redacted]. At approximately 9:40 PM on 5/23/24, [CNA #1] reported to LPN #1 that [Resident #51's] [redacted] was [redacted] and stated that she observed [Resident #51] [redacted] their [redacted]. Upon review of the camera footage in the [redacted] the resident [redacted] from their wheelchair and [CNA #1] [redacted] [Resident #51's] [redacted] above the [redacted] and [redacted] and appeared to be [redacted] (no audio). A few minutes later, the resident [redacted]. CNA #1 had the resident [redacted] and [redacted] [Resident #51's] wheelchair using [redacted] and [redacted] as a [redacted] As the resident [redacted], [CNA #1] [redacted] on [Resident #51's] [redacted] That caused [redacted] to [Resident #51]. [Resident #51] [redacted] to [redacted] themselves and [redacted] and [redacted] hit [CNA #1]. [Resident #51] [redacted] from the table and [redacted] behind them at [CNA #1]. [CNA #1] continued to [redacted] [Resident #51] [redacted] During the [redacted] between the resident and [CNA #1], the [redacted] occurred. During that time, [CNA #1] did not make any attempts to [redacted] the resident by [redacted] or [redacted].

A review of the "Incident Investigation

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Conclusion" revealed that "It has been determined after gathering statements and watching footage of the incident that [CNA #1]... used NJ Exec Order 26.4b1 on [Resident #51] which resulted in a NJ Exec Order 26.4b1 ..."

The surveyor reviewed Resident #51's medical record.

A review of the Admission Record face sheet (an admission summary) revealed the resident was admitted to the facility with diagnoses which included but were not limited to; NJ Exec Order 26.4b1 [redacted]

A review of the quarterly Minimum Data Set (MDS), an assessment tool dated NJ Exec Order 26.4b1 revealed Resident #51 had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, indicating that the resident had NJ Exec Order 26.4b1 [redacted].

A review of the Individual Comprehensive Care Plan (ICCP) included a focus area initiated on NJ Exec Order 26.4b, that the resident was at risk for NJ Exec Order 26.4b and NJ Exec Order 26.4b1 with an intervention dated NJ Exec Order 26.4b to apply NJ Exec Order 26.4b1 or [redacted] An additional focus area initiated on NJ Exec Order 26.4b1 for personalized care, included an intervention that the resident NJ Exec Order 26.4b1 [redacted]. The ICCP also included a focus area revised on [redacted], for NJ Exec Order 26.4b1 [redacted] with an intervention dated NJ Exec Order 26.4b, that if the resident becomes NJ Exec Order 26.4b at a team member, have another team member try to NJ Exec Order 26.4b1 the situation.

A review of a NJ Exec Order 26.4b1 dated NJ Exec Order 26.4b

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F 600	Continued From page 10 indicated Resident #51 had "NJ Exec Order 26.4b1." A second NJ Exec Order 26.4b1 dated NJ Exec Order 26.4b, indicated the resident had NJ Exec Order 26.4b1 of the NJ Exec Order 26.4b1 and a NJ Exec Order 26.4b1. On 3/23/25 at 1:54 PM, the US FOIA (b)(6) provided two surveyors access to the video surveillance of the NJ Exec Order 2 incident that occurred on NJ Exec Order 26.4b. The surveyors observed the following occurred on NJ Ex Order 26.4(b): At 9:33 PM, the footage showed the back of Resident #51 in their wheelchair (w/c) seated at a table in the NJ Exec Order 2. The resident was wearing a NJ Exec Order 26.4b1. To the right of the resident, Resident #36 was observed seated in their w/c at the same table next to Resident #51. CNA #1 was observed to the left of Resident #51 with NJ Exec Order 26.4b of Resident #51 who was NJ Exec Order 26.4b1. CNA #1 was NJ Exec Order 26 the resident NJ Exec Orde and NJ Exec Order 26.4b1 the resident from NJ Exec Order 26.4b1. At 9:34.16 PM, CNA #1 stood and walked behind Resident #51. CNA #1 pushed Resident #51's w/c NJ Ex Order 26.4(b)(1) the table and NJ Ex Order 26.4 the NJ Ex O of the w/c. Then CNA #1 moved her chair to be NJ Exec Order 26.4b1 behind Resident #51 and CNA #1 had NJ Exec Order 26.4b1 on the resident's NJ Exec Orde CNA #1 appeared to be speaking in Resident #51's ear. Resident #36 was observed at that time NJ Exec Order 26.4b1 from the table slightly. At 9:35.19 PM, Resident #36 was moving their w/c NJ Exec Order 26.4b1 themselves from the table. At 9:36.07 PM, Resident #51 NJ Exec Order 26.4b1 and each time was NJ Exec Order 26.4b1	F 600		

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	315166	A. BUILDING _____ B. WING _____	C 03/28/2025

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F 600	Continued From page 11	F 600		

NJ Exec Orde into the w/c by CNA #1. CNA #1 was NJ Exec Order 26.4b1 the resident and was NJ Exec Order 26 in the w/c.

At 9:36.13 PM, Resident #51 was observed trying to NJ Exec Orde CNA #1 away by NJ Exec Order 26.4b1 CNA #1 again NJ Exec Order 26.4b1 Resident #51 towards the back of the w/c. The resident NJ Exec Order 26.4b1 , and then CNA #1 pushed the resident down into the w/c. CNA #1 then placed Resident #51 in a "NJ Exec Orde by NJ Exec Order 26.4b1 to the resident's NJ Exec Orde and their NJ Exec Order 26.4b1 in a NJ Exec Order 26.4b1 by the NJ Exec Orde of the resident's NJ Exec Orde

At 9:36.22 PM, CNA #1 was observed with both of her hands NJ Exec Order 26.4b1 on Resident #51's NJ Exec Order 26.4b1 .

At 9:36.56 PM, CNA #1 was still NJ Exec Order 26.4b1 Resident #51 and observed to be NJ Exec Order 26.4b the resident NJ Exec Order 26.4b1 with NJ Exec Order 26.4b1 against Resident #51's NJ Exec Order 26.4b1

At 9:37.25 PM, CNA #1 was observed with NJ Exec The resident began to NJ Exec Order 26.4b by NJ Exec Order 26.4b1 from CNA #1 and NJ Exec Order 26.4b1 . Resident #51 next NJ Exec Order 2 towards the NJ Exec Order 26.4b1 but was NJ Exec Order 26.4b1 CNA #1 continues to NJ Exec Order 26 the resident. Resident #36 NJ Exec Order 26.4b1 back and leaves the room. CNA #1 again NJ Exec Orde Resident #51 NJ Exec Orde by the NJ Exec Orde and NJ Exec Order 26.4b1 as the resident NJ Exec Order 26.4b1 .

At 9:37.37 PM, Resident #51 attempts to stand and CNA #1 was observed NJ Exec Order 26.4b1 on the resident's NJ Exec Order 26.4b1 and NJ Exec Order 26.4b the resident

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F 600	Continued From page 12 [redacted] into their w/c. At 9:38.08 PM, CNA #1 stands, unlocked the w/c and pushed the w/c with the resident into the hall. At 9:39.31 PM, LPN #1 was observed in the hallway and wheeling Resident #51 down the hall. The video revealed that CNA #1 [redacted] and [redacted] Resident #51 eight times in the five minutes of video footage. Resident #36 who was observed in the video witnessing CNA #1 [redacted] Resident #51 was not identified in the facility's investigation or assessed by the facility for potential [redacted] after observing the [redacted] by [CNA #1] against [Resident #51] on [redacted]. The surveyor reviewed Resident #36's medical record. A review of the quarterly MDS dated [redacted] revealed that Resident #36 had a BIMS score of [redacted] out of 15, which indicated that the resident had [redacted]. A review of the Admission Record face sheet revealed Resident #36 had diagnoses which included but were not limited to; [redacted] A review of the ICCP included a focus area dated [redacted], that the resident had potential to be a [redacted] with interventions including to provide [redacted] or [redacted] An additional focus area dated [redacted], for [redacted] with an intervention to monitor for signs of [redacted]. The ICCP also included a focus area dated [redacted] for [redacted] to	F 600		

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be NJ Exec Order 26.4b1 or NJ Exec Order 26.4b1 with an intervention to NJ Exec Order 26.4b1 and speak NJ Exec Order 2 and NJ Exec Order 26

A review of the Progress Notes (PN) revealed a "Late Entry" dated NJ Exec Order 26.4, that Resident #36 was seen for a "follow up NJ Exec Order 26.4b1" and did not include the incident observed on NJ Exec Order 26.

The surveyor reviewed the PNs through NJ Exec Order 26.4b and there was no documented evidence that referenced Resident #36 witnessing the incident of NJ Exec Order 26.4b1

On 3/24/25 at 12:15 PM, the US FOIA (b)(6) were interviewed by two surveyors. The US FOIA (b)(6) stated he was the US FOIA (b)(6) at the time of the incident and confirmed that he and the US FOIA (b)(were both working at the facility when the incident occurred. The US FOIA (b) stated the NJ Exec Order 26.4b had to be investigated to figure out what happened so the video was reviewed, and they found CNA #1 was 'NJ Exec Order 26.4b1 When asked about signs of NJ Exec Order 26.4b1, the US FOIA (b) stated there could be NJ Exec Order 26.4b1 . The US FOIA (b) stated that LPN #1 was still working at the facility. When asked what was determined regarding Resident #51's NJ Exec Order 26 the US FOIA (b) stated, "I do not remember." When asked what the expectation would be, the US FOIA (b) stated, "We would try to figure out what caused the NJ Exec Order 26.4 When asked the procedure upon discovery of a NJ Exec Order 26.4b1 , the US FOIA (b)(stated it should be reported to the US FOIA (b)(6) further stated that CNA #1 reported that the resident had a NJ Exec Order 26.4b The US FOIA (b)(6) who identified an NJ Exec Order should notify the nurse and the nurse investigates. There would be an incident report

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F 600	Continued From page 14 completed. The [US FOIA (b)] stated CNA #1 reported the resident [NJ Exec Order 26.4b1] so "we" (the facility) would not question her. When asked about the [NJ Exec Order 26] the [US FOIA (b)] stated they would look at the [NJ Exec Order 26.4b1]. The [US FOIA (b)(6)] stated that when they viewed the video, they observed that the incident was [NJ Exec Order] and not what CNA #1 had reported. When asked about the investigation process and if an [US FOIA (b)] would be responsible to make the determination of [NJ Exec Order] for the [NJ Exec Order 26.4b1], the [US FOIA (b)] stated the [US FOIA (b)] would report to the [US FOIA (b)(6)] but that there would not be a statement from the [US FOIA (b)(6)] unless there was additional information to add. The [US FOIA (b)] added that the [US FOIA (b)(6)] would have to assess the [NJ Exec Order] at that time but would not "necessarily" document the assessment. The [US FOIA (b)] stated she would look for any additional information. On 3/24/25 at 2:16 PM, during an interview with the [US FOIA (b)(6)] in the presence of the survey team, the surveyor asked the [US FOIA (b)(6)] if any other residents were assessed to [NJ Exec Order 26.4b1] since CNA #1 proceeded to work two hours after the [NJ Exec Order 26.4b1] were identified on Resident #51. The [US FOIA (b)(6)] stated, we "were looking at the event and, did not check any other residents on the neighborhood." The [US FOIA (b)(6)] stated they assumed that it was an isolated incident. When asked if Resident #36 was assessed, the [US FOIA (b)(6)] stated, "I do not know. There was [NJ Exec Order 26.4b1] [regarding Resident #36] reported in their [NJ Exec Order 26.4b1] On 3/25/25 at 1:05 PM, during a telephone interview in the presence of the survey team, LPN #1 was asked about the incident. LPN #1 stated, "I do not even recall the [NJ Exec Order 26] but I remember	F 600		

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the NJ Exec Order 26.4b1." LPN #1 stated she asked CNA #1 what happened, and she thought it was a mishap 'NJ Exec Order 26.4b1." LPN #1 stated that she did not know about Resident #51 but that 'NJ Exec Order 26.4b1" and that it would be for a reason and that if CNA #1 could not NJ Exec Order 26.4 the resident, she should have called for help. LPN #1 acknowledged that no supervisor came to assess Resident #51. LPN #1 stated she was later informed of the NJ Exec Order 26 but she was not provided any education after the incident. When asked what constituted NJ Exec Order 26 LPN #1 stated 'NJ Exec Order 26.4b1" resident, NJ Exec Order 26.4b1. When asked about being barricaded between a table and a staff member, LPN #1 stated, "oh certainly that would be NJ Exec Order 2 if they [residents] are NJ Exec Order 26.4b1." LPN #1 stated she asked Resident #51 what happened but that the resident was NJ Exec Order 26.4b1.

On 3/27/25 at 9:55 AM, the US FOIA (b) acknowledged that an LPN could not do an assessment and that there was no documentation that the US FOIA (b)(6) came to assess Resident #51 or Resident #36.

On 3/27/25 at 2:01 PM, the US FOIA (b)(6) were in the conference room with the survey team. They confirmed that Resident #36 was "only coincidentally" seen on NJ Exec Order 26, but not specifically to address witnessing the NJ Exec Order 2 of Resident #51.

A review of the facility provided transcript revealed that LPN #1 had completed an "Annual Abuse" review on NJ Exec Order 26.4b

A review of the facility provided "Team Member

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Handbook Acknowledgment" signed and dated 3/14/22, by CNA #1, included but was not limited to; "Abuse Policy"...will not permit residents to be subjected to abuse by any person. Physical abuse included the infliction of injury including but not limited to pulling, twisting, restraints, controlling behavior through the use of forcibly handling a resident.

A review of the facility provided education and performance records revealed the following: CNA #1 had completed "Annual Abuse" review on 3/12/24; "Restraints and Alternatives" training on 4/24/24; "Resident Rights and Abuse" training on 4/30/24; and "Restraint-Free Environment" training on 3/13/24. The "Performance Evaluation" dated 2/4/24, noted that CNA #1 was noted as "Improvement Needed" with comments that included: "does not do well with change and continues to do things as she always has."

An acceptable Removal Plan (RP) was received on 3/27/25 at 2:22 PM, which indicated the action the facility took to prevent serious harm from occurring or recurring. The facility implemented a corrective action plan to remediate the deficient practice including; on [NJ Exec Order 26.4b] Resident #51 and Resident #36 was assessed by the [US FOIA (b)(6)] to confirm [NJ Exec Order 26.4b1] related to the [NJ Exec Order 26.4b] incident, all nurse managers and supervisors would be required to respond to all reported incidents and accidents, and the Abuse Policy was amended to include any staff involved with an [NJ Exec Order 26.4] to a resident must be removed immediately from resident contact and all residents that had contact with the [NJ Exec Order 26] would be assessed and/or interviewed to ensure [NJ Exec Order 26.4b1]

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F 600	Continued From page 17 [redacted] had occurred. The survey team verified the implementation of the RP during the continuation of the on-site survey on on 3/28/25 at 9:20 AM.	F 600		
F 610 SS=K	NJAC 8:39-4.1(a)(5) Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Complaint #: NJ 174085 Refer to F 600 Based on observation, interview, record review, and review of pertinent documentation, it was determined that the facility failed to thoroughly investigate [redacted] to rule out	F 610	Criteria #1 During our annual Department of Health re-certification survey, surveyors investigated an event that our community had self-reported on May 25, 2024, involving inappropriate handling of one of our residents by a staff Certified Nursing Assistant. The Certified Nursing Assistant	4/21/25

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F 610	Continued From page 18 NJ Ex Order 26.4 This deficient practice was identified for 1 of 2 residents reviewed for NJ Exec Order 2 (Resident #51). A review of an NJ Exec Order 2 investigation revealed on NJ Exec Order 26.4 at 9:45 PM, on the NJ Exec Order 26.4b1 Unit, a Licensed Practical Nurse (LPN #1) was informed by a Certified Nurse Aide (CNA #1) that a NJ Exec Order 26.4b1 (Resident #51) had a 7 NJ Exec Order 26.4b1 that required NJ Exec Order 26.4b1) from the resident (Resident #51) NJ Exec Order 26.4b1 themselves and had a NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 . Observation of video footage from the time of the incident revealed that on NJ Exec Order 26.4 , CNA #1 was observed NJ Exec Order 26 NJ Exec Order 26.4b1 Resident #51 in their wheelchair to NJ Exec Order 26.4b1 the resident's wheelchair from NJ Ex Order 26.4 with a chair and the CNA's body. The video footage identified a second resident, Resident #36, witnessed the incident and NJ Exec Order 26.4b1 themselves away from the situation. An interview on 3/24/25, with the US FOIA (b)(6) revealed that the incident was not initially investigated as NJ Exec Order 2 until the former US FOIA (b)(6) reviewed the video footage two days later NJ Exec Order 26.4) and identified that CNA #1 NJ Exec Order 26. Resident #51. The administration confirmed that CNA #1 finished working their shift on NJ Exec Order 26.4b and had access to all the residents on the NJ Exec Order 2 unit. Resident #36 was not assessed after the incident to rule out NJ Exec Order 26.4b1 The facility's failure to implement their NJ Exec Order 2 policy by immediately conducting a thorough investigation to ensure all residents are NJ Exec 2 from NJ Exec Order 2 posed a likelihood of NJ Exec Order 26.4b1 , or	F 610	was placed on administrative leave immediately following observation of confirmed NJ Exec Order 26.4b1 of the resident observed on videotape from an incident NJ Exec Order 26.4b1 . Surveyors determined that the Certified Nursing Assistant should have been NJ Exec Order 26.4b1 from our community at the time of the originally NJ Exec Order 26.4b1 . Certified Nursing Assistant employment was NJ Exec Order 26.4b1 on NJ Exec Order 26.4b1 . Resident # 51 was evaluated by provider on NJ Exec Order 26.4 related to NJ Exec Order 26.4 incident, NJ Exec Order 26.4b1 Resident #36 evaluated by provider for follow-up NJ Exec Order 26.4b1 . On NJ Exec Order 26.4 resident #51 was seen by NJ Exec Order 26.4b1 NP. Criteria #2 Because all residents on our secured dementia unit could be affected by this deficient practice, all present residents on that unit were assessed by the nursing team to ensure there were no injuries to any of the residents. No injuries were identified. Criteria #3 Under the direction of the Director of Nursing and in cooperation with the community Administrator, Our Abuse Policy was amended to reflect the following: 1. Staff involved with any incident or accident of unknown origin must remove the involved staff member immediately. That person must leave the clinical area and not have further contact with residents until the investigation is	

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F 610	Continued From page 19 [redacted] to all residents. This resulted in an Immediate Jeopardy (IJ) situation. The IJ situation began on [redacted] at 9:33 PM, when CNA #1 was observed [redacted] Resident #51 [redacted] The facility's Administration were notified of the IJ on [redacted] at 2:54 PM. An acceptable Removal Plan (RP) was received on [redacted] at 2:22 PM. The RP was verified on-site by the survey team on 3/28/25 at 9:20 AM, during the continuation of the survey. Findings include: A review of the facility's policy in effect the date of the incident, "Abuse and Neglect", dated 5/4/23, included Policy: the [facility] will not permit residents to be subjected to any form of abuse/neglect...Abuse definition is the willful infliction of injury...intimidation,...mental anguish. Injuries of unknown source - classified...when both of the following conditions are met a.) source of the injury was not observed or the source could not be explained by the resident. AND b.) the injury is suspicious because of the extent, location,...Identification/Investigation/Protection: 1. The [facility] will identify all types of events including...bruising of residents...that may constitute abuse. 2...appropriate action will be taken to safeguard the resident from harm "while the incident is fully investigated." Actions to include...team member placed on fact finding leave pending investigation. Social Worker referral. Psychology consultation as appropriate. Response: all reported occurrences will be fully investigated...to determine what actions are necessary and what changes are needed to policies and procedures to prevent further occurrences. Abuse Training: to ensure proper	F 610	completed. 2. All other residents who are on the alleged perpetrator's assignment or has contact with the alleged perpetrator must be assessed and/or interviewed to ensure no physical or psychological injuries exist. 3. A Supervisor or Manager must respond to all accidents and incidents in person to determine if the injury origin is unknown. 4. The Supervisor/Manager must call the Administrator for all cases of injuries/accidents of unknown origin. 5. Any event which is unexplainable and suspicious in nature will be reported within 2 hours to the Department of Health. 6. A spreadsheet was developed to document all incidents and accidents. The spreadsheet will indicate who the Supervisor/Manager was who assessed the situation, what they found to be any causal factors and whether or not they determined that the event was suspicious for abuse and if so if the appropriate next steps were taken. All nurses and Certified Nursing Assistants on duty were re-educated on the revised Abuse and Neglect policy and thorough investigation post a new incident. No staff member was permitted to work until required training was complete. Education included contracted staff. Criteria #4 Our Quality Assurance and Performance Improvement plan was revised under the direction of the Administrator to monitor compliant practice with required	

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F 610	Continued From page 20 training of new and existing team members on abuse/neglect prevention, identification and protection of residents. 6. Characteristics of the resident population at risk for abuse...cognitively impaired, psychological medical problems, communication disorders, those who require extensive nursing care. 7. Training on identifying suspicious bruising... A review of the facility policy, "Incident Reporting-Injuries of Unknown Origin/Source", revised 5/16/16, included but was not limited to; Procedure: B. all injuries of unknown origin/source shall be investigated by the nurse on duty and/or Supervisor ... E. the nurse will ask the resident how the injury occurred and document their answer. F. the nurse shall obtain statements from everyone on the shift ... also from team members for 24 hours prior to the discovery of the injury. G. The nurse shall contact the Supervisor and notify them. On 3/23/25 at 1:54 PM, the [US FOIA (b)(6)] provided a copy of the completed Facility Reportable Event (FRE) reported to the New Jersey Department of Health (NJDOH), "Incident Investigation" dated [NJ Exec Order 26.4b] , for Resident #51 including all documentation and statements which revealed the following: A review of the FRE, included Date/Time of Event: [NJ Exec Order 26.4b] at 9:35 PM. The location of the incident was the NJ Exec Order 26.4b1 and the type of incident was NJ Exec Order 26.4b1 . The Description of the Event included: CNA #1 stated she asked Resident #51 to [NJ Exec Order 26.4b1] and she observed [Resident #51] [NJ Exec Order 26.4b] their [NJ Exec O] . "As this is [NJ Exec Order 26.4b] for the resident" we requested camera	F 610	documentation of such. We will review our spreadsheet of incidents/accidents daily for 3 months to ensure compliance with the above components of our Abuse policy. Results of the observations will be reviewed at quarterly Quality Assurance and Performance Improvement meetings. The Quality Assurance and Performance Improvement committee will review outcomes and modify the plan as needed	

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footage of the [NJ Exec Order] for that time period. The video was obtained today [NJ Exec Order 26.4b]) and viewed by the [US FOIA (b)(6)] (former). The "video showed [CNA #1] NJ Exec Order 26.4b1 [Resident #51] from behind with NJ Exec Order 26.4b1 on [Resident #51's] NJ Exec Order 26.4b1 [Resident #51] to NJ Exec Order 26.4b1 . [Resident #51] was NJ Exec Order 26.4b1 from [CNA #1] and NJ Exec Order 26.4b1 [CNA #1]. [CNA #1] [NJ Exec Order 26.4b] [Resident #51's] [NJ Exec O] and [NJ Exec Orde] This is likely the cause of the NJ Exec Order 26.4b1. [Resident #51] showed [CNA #1] the NJ Exec Order 26.4b1 and [CNA #1] NJ Exec Order 26.4b1 [Resident #51's] [NJ Exec O] and [NJ Exec Order 26.] the resident out of the [NJ Exec Orde] to the nurse." Others notified: [name redacted] [NJ Exec Order 2] Department after video review.

A review of the "Incident Investigation" submitted with the FRE included: 'NJ Exec Order 26.4b1 " Date: [NJ Exec Order 26.4b] and signed by the former [US FOIA (b)(6)] on [NJ Exec Order 26.4] . A statement summary from LPN #1 revealed ... [CNA #1] told her that she asked [Resident #51] to NJ Exec Order 26.4b1 and then observed [Resident #51] NJ Exec Order 26.4b1 . Investigational Findings:...[Resident #51] can NJ Exec Order 26.4b1 . At approximately 9:40 PM on 5/23/24, [CNA #1] reported to LPN #1 that [Resident #51's] [NJ Exec O] was [NJ Exec Order 26.4b] and stated that she observed [Resident #51] NJ Exec Order 26.4b1. Upon review of the camera footage in the Bistro, the resident NJ Exec Order 26.4b1 and [CNA #1] [NJ Exec Order 26.4b] [Resident #51's] [NJ Exec O] above the [NJ Exec], and appeared to be [NJ Exec Order 26.4b1). A few minutes later, the resident NJ Exec Order 26.4b1. CNA #1 had the resident [NJ Exec Order 26.4b] and moved [Resident

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F 610	Continued From page 22 #51's] wheelchair using her body and chair as a [redacted] As the resident attempted to stand, [CNA #1] [redacted] on [Resident #51's] [redacted] That caused [redacted] to [Resident #51]. [Resident #51] [redacted] [CNA #1]. [Resident #51] picked up [redacted] from the table and attempted to [redacted] behind them at [CNA #1]. [CNA #1] continued to [redacted] [Resident #51] [redacted] During the [redacted] between the resident and [CNA #1], the skin [redacted] occurred. During that time, [CNA #1] did not make any attempts to [redacted] the resident by [redacted] or [redacted] in activities. A review of the "Incident Investigation Conclusion" revealed that "It has been determined after gathering statements and watching footage of the incident that [CNA #1]... used [redacted] on [Resident #51] which resulted in a [redacted]..." A Progress Note dated [redacted] at 2:00 PM, written by LPN #1, included: "Incident Date: [redacted] / 9:45 PM; Individual that discovered incident: CNA #1, [redacted] Notifications: (Physician, Family/Sponsor, Nursing Supervisor: List contact name and time notified): Info [information] placed in [redacted] [physician] book." A review of the Admission Record face sheet (an admission summary) revealed the resident was admitted to the facility with diagnoses which included but were not limited to; [redacted]	F 610		

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with NJ Exec Order 26.4b1.

A review of the quarterly Minimum Data Set (MDS), an assessment tool dated NJ Exec Order 26.4, revealed Resident #51 had a Brief Interview for Mental Status (BIMS) score of NJ Exec out of 15, indicating that the resident had NJ Exec Order 26.4b1

A review of the Individual Comprehensive Care Plan (ICCP) included a focus area initiated on NJ Exec Order 26.4b, that the resident was at risk for NJ Exec Order 26.4b and NJ Exec Order 26.4b1 with an intervention dated NJ Exec Order 26.4, to apply NJ Exec Order 26.4b1. An additional focus area initiated on NJ Exec Order 26.4b, for personalized care, included an intervention that the resident preferred a 9:00 PM bedtime. The ICCP also included a focus area revised on NJ Exec Order 26.4b1 for NJ Exec Order 26.4b1 with an intervention dated NJ Exec Order 26.4b1, that if the resident becomes NJ Exec Order 26.4b at a team member, have another team member try to NJ Exec Order 26.4b1 the situation.

A review of a Nursing Progress Note (NPN) dated NJ Exec Order 26.4 at 9:45 PM, by LPN #1, documented a NJ Exec Order 26.4b1 note that identified a NJ Exec Order 26.4b to the NJ Exec Order 26.4b1 of the NJ Exec Order 26.4b1. The NPN further noted that the resident was 'NJ Exec Order 26.4b1.

A review of a typed statement signed by LPN #1, dated NJ Exec Order 26, documented that CNA #1 reported that while she was observing the resident in the NJ Exec Order for NJ Exec Order 26 Resident #51 was observed to be NJ Exec Order 26.4 and NJ Exec Order 26.4b1 (w/c). CNA #1 reported the resident 'NJ Exec Order 26.4b1

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NJ Exec Orde and observed Resident #51 had "NJ Exec Order 26.4b1 ." (There was no documentation that CNA #1 had reported a NJ Exec Order 2 on the resident's NJ Exec Orde or the possible causal factor of the NJ Exec Order 2 to the NJ Exec Order 26.4b1

A statement on an "Accident/Incident Statement/Interview Form" NJ Exec Order 26.4b1, from CNA #1, documented...Resident #51 was sitting at the table with me (and all of a sudden, [Resident #51] NJ Exec Order 26.4b1 w/c backwards. "NJ Exec Order 26.4b1 ...Then all of a sudden, "NJ Exec Order 26.4b1" and "NJ Exec Order 26.4b1 [CNA #1] with NJ Exec Order 26.4b1 and [the resident] thought had my [CNA #1's] NJ Exec Orde but in reality had own NJ Exec Orde and NJ Exec Order 26.4b1 on NJ Exec O , but NJ Exec Order 26.4b1 themselves." [Resident #51] was "NJ Exec Order 26.4b1." She further documented that she kept NJ Exec Order 2 for LPN #1 and that she was in the office and when LPN #1 finally did come, I showed her the NJ Exec Order 26.4b1 Resident #51's NJ Exec O [Resident #51] NJ Exec Order 26.4b1. There was a picture NJ Exec Order 26.4b1 [Resident #51] trying not to let the wheelchair tip over." The statement section for a Manager/Supervisor signature was left blank and undated.

A review of the facility provided "NJ Exec Order 26.4b1" report dated NJ Exec Order 26.4 at 9:45 PM, completed by LPN #1, included but was not limited to; ... CNA #1 stated she asked Resident #51 to NJ Exec Order 26.4b1 and observed the resident NJ Exec Order 26. their NJ Exec Order 26.4b causing a NJ Exec Order 26.4b1. When asked how the incident happened, Resident #51 replied NJ Exec Order 2 The "Witnesses" section revealed "no witnesses

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F 610	Continued From page 25 found." A review of a typed statement signed by the [US FOIA (b)(6) redacted], and dated [NJ Ex Order 26.4(b) redacted], documented that when LPN #1 asked Resident #51 what happened, the resident replied, "Fix it" which contraindicated LPN #1's statement. A statement on the facility "Accident/Incident Statement/Interview Form" dated [NJ Exec Order 26.4 redacted], from CNA #2 on the unit, documented that the resident did not have any [NJ Exec Order 26.4b1 redacted] prior to the incident. CNA #2 did not indicate if CNA #1 was [NJ Exec Order 26.4b1 redacted] for LPN #1. (There was no statement or assessment provided from the [US FOIA (b)(6) redacted] who the facility stated had been made aware.) At the same time and date [NJ Exec Order 26.4b1 redacted] at 1:54 PM) that the [US FOIA (b)(6) redacted] provided the investigation, the [US FOIA (b)(6) redacted] provided two surveyors access to the video surveillance of the [NJ Ex Order 26 redacted] incident that occurred on [NJ Exec Order 26.4 redacted]. The surveyors observed the following occurred on [NJ Ex Order 26.4(b) redacted] At 9:33 PM, the footage showed the back of Resident #51 in their wheelchair (w/c) seated at a table in the [NJ Exec Order redacted] The resident was [NJ Exec Order 26.4b1 redacted] To the right of the resident, Resident #36 was observed seated in their w/c at the same table next to Resident #51. CNA #1 was observed to the left of Resident #51 with [NJ Exec Order 26.4b1 redacted] of Resident #51 who was NJ Exec Order 26.4b1. CNA #1 was [NJ Exec Order 26 redacted] the resident [NJ Exec Orde redacted] and [NJ Exec Order 26.4b1 redacted] the resident from [NJ Exec Order 26.4b1 redacted] At 9:34.16 PM, CNA #1 stood and walked behind	F 610		

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Resident #51. CNA #1 pushed Resident #51's w/c NJ Ex Order 26.4(b)(1) the table and NJ Ex Order 26.4 the NJ Ex O of the w/c. Then CNA #1 moved her chair to be NJ Exec Order 26.4b1 #51 and CNA #1 NJ Exec Order 26.4b1 CNA #1 appeared to be speaking in Resident #51's ear. Resident #36 was observed at that time NJ Exec Order 26.4b1 .

At 9:35.19 PM, Resident #36 was moving their w/c NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 themselves from the table.

At 9:36.07 PM, Resident #51 NJ Exec Order 26.4b1 up twice and each time was NJ Exec Order 26.4b1 NJ Ex Order the w/c by CNA #1. CNA #1 was NJ Exec Order 26.4b1 in the w/c.

At 9:36.13 PM, Resident #51 was observed trying to NJ Exec Ord CNA #1 NJ Exec Order 26.4b1 with NJ Exec Order 26.4b1 . CNA #1 again NJ Exec Order 26.4b1 Resident #51 towards the back of the w/c. The resident attempted to NJ Exec Order 26.4b1 , and then CNA #1 NJ Exec Order 26 the resident NJ Exec Ord into the w/c. CNA #1 then NJ Exec Order 2 Resident #51 in a ' NJ Exec Ord by NJ Exec Order 26.4b1

At 9:36.22 PM, CNA #1 was observed with both of her NJ Exec Order 26.4b1 on Resident #51's NJ Exec Order 26.4b1 preventing Resident #51's NJ Exec Order 26.4b1

At 9:36.56 PM, CNA #1 was still positioned behind Resident #51 and observed to be NJ Exec Order 26.4b the NJ Exec Order 26.4b1 with NJ Exec Order 26.4b1 against Resident #51's NJ Exec Order 26.4b1

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F 610	Continued From page 27 At 9:37.25 PM, CNA #1 was observed with her NJ Exec Order 26.4b1 The resident began to NJ Exec Order 26.4b1 by NJ Exec Order 26.4b1 from CNA #1 and NJ Exec Order 26.4b1. Resident #51 next NJ Exec Order 26.4b1 towards the NJ Exec Order 26.4b1 but was NJ Exec Order 26.4b1 CNA #1 continues to NJ Exec Order 26.4b1 the resident. Resident #36 NJ Exec Order 26.4b1 back and leaves the room. CNA #1 again NJ Exec Order 26.4b1 Resident #51 NJ Exec Order 26.4b1 as the resident NJ Exec Order 26.4b1. At 9:37.37 PM, Resident #51 NJ Exec Order 26.4b1 and CNA #1 was observed placing NJ Exec Order 26.4b1 on the resident's NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 the resident NJ Ex Order 26.4(b)(1) their w/c. At 9:38.08 PM, CNA #1 stands, unlocked the w/c and pushed the w/c with the resident into the hall. At 9:39.31 PM, LPN #1 was observed in the hallway and NJ Ex Order 26.4(b)(1) Resident #51 down the hall. The video revealed that CNA #1 NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 Resident #51 eight times in the five minutes of video footage. Resident #36 who was observed in the video witnessing CNA #1 NJ Exec Order 26.4b1 Resident #51 was not identified in the facility's investigation or assessed by the facility for NJ Exec Order 26.4b1 after observing the NJ Exec Order 26.4b1 by [CNA #1] against [Resident #51] on NJ Exec Order 26.4b1 CNA #1's statement provided in the investigation did not include Resident #36 was at the table with Resident #51 and herself. On 3/24/25 at 12:15 PM, the current US FOIA (b)(6) were interviewed by two surveyors. The US FOIA (b) stated the NJ Exec Order 26.4b1 had to be investigated	F 610		

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to figure out what happened so the video was reviewed. The [US FOIA (b)] stated signs of [NJ Exec Order 2] could be NJ Exec Order 26.4b1 [redacted]. When asked what was determined regarding Resident #51's [NJ Exec Order 2] the [US FOIA (b)] stated, "I do not remember." When asked what the expectation would be, the [US FOIA (b)] stated, "We would try to figure out what caused the [NJ Exec Order 26.4] When asked the procedure upon discovery of a NJ Exec Order 26.4b1, the [US FOIA (b)] stated it should be reported to the [US FOIA (b)(6)] [redacted] stated the CNA notifies the nurse and the nurse investigates, and there would be an incident report completed. The [US FOIA (b)] stated that CNA #1 reported that the resident NJ Exec Order 26.4b1, so "we" (the facility) would not question CNA #1 any further. When asked about the [NJ Exec Order 2] the [US FOIA (b)] stated they would look at the type of [NJ Exec Order 2] such as a [NJ Exec Order 26.4b1]. When asked about the investigation process and if an LPN would be responsible to make the determination of [NJ Exec Order 2] for a [NJ Exec Order 26.4b] [redacted] the [US FOIA (b)] stated the LPN would have to report to the NS regarding the [NJ Exec Order 2] and the NS would not document a statement unless they felt they had something to add. It was not consistently required. The [US FOIA (b)] added that the NS was responsible to assess the [NJ Exec Order 2] at that time, but would not have to document the assessment. The facility could not provide any documentation from the NS. When asked about what should have happened with the investigation process, the [US FOIA (b)] stated that the nurse should have investigated the [NJ Exec Ord] and completed an incident report. The [US FOIA (b)] further stated that the nurse and supervisor should have investigated the incident "that night" and they should have obtained statements from staff.

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F 610	Continued From page 29 On 3/24/25 at 2:16 PM, during an interview with two surveyors regarding the incident that occurred on [redacted], the [redacted] stated, "yes this was [redacted] and confirmed that the [redacted]) did not visit with any residents after the incident. The [redacted] stated, "we were looking at the event and did not go further to check other residents. I believe we thought it was isolated to this event." The [redacted] confirmed that CNA #1 "finished her shift" after the [redacted] occurred on [redacted], and stated CNA #1 "[redacted] Resident #51. The [redacted] stated they "were looking at the event and did not check any other residents on the neighborhood" and stated we "assumed that it [the [redacted] was isolated." The [redacted] was unable to provide any documentation or confirm that all 14 residents were assessed to ensure they were not [redacted] When asked if Resident #36 was assessed, the [redacted] stated, "I do not know. There was [redacted] [regarding Resident #36] reported in [redacted]." On 3/24/25 at 2:58 PM, the surveyor interviewed LPN #3, who stated that if there was a resident with an NJ Exec Order 26.4b1, the nurse first saw what care the resident needed, then asked the resident if they were able to explain what happened, and then informed the supervisor. LPN #3 further stated that she documented the description of the [redacted] LPN #3 stated that if it looked like a [redacted] she checked the resident's [redacted] and checked the CNA's [redacted] LPN #3 stated if the NJ Exec Order 26.4b1, the supervisors initiated the investigation and looked back about 72 hours to obtain statements. On 3/24/25 at 2:59 PM, during an interview with LPN #2 regarding the investigation process, she	F 610		

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stated that if a CNA reported a NJ Exec Order 2 or any NJ Exec Order the protocol was to inform the supervisor and notify the physician and the family. If NJ Exec Order 2 was suspected the supervisor had to report it.

On 3/24/25 at 3:06 PM, during an interview with a US FOIA (b)(6)), who stated the process when an NJ Exec Order 26.4b1 was identified, it was investigated by speaking to all the staff involved with the resident's care. The US FOIA stated she tried to find out what happened and completed an incident report. The US FOIA stated if NJ Exec Order 2 was suspected, the US FOIA (b)(6) were notified, and the police were notified as well.

On 3/25/25 at 1:05 PM, during a telephone interview in the presence of the survey team, LPN #1 was asked about the incident. LPN #1 stated, "I do not even recall the NJ Exec Order 26 but I remember the NJ Exec Order 26.4b1." LPN #1 stated she asked CNA #1 what happened, and she "thought it was a NJ Exec Order 26.4b1." LPN #1 stated if a resident had an NJ Exec Order 26.4b1, she would ask a witness what happened and would document what they had said happened. LPN #1 stated she notified the supervisor after she attended to any NJ Exec Order 26.4 LPN #1 further stated she was not present during the incident and she documented what had been told by CNA #1. LPN #1 stated she had not observed Resident #51 NJ Exec Order 26.4b1. LPN #1 stated that if she NJ Exec Order 26 " LPN #1 further stated that if there was an NJ Exec Order 26.4b1, there needed to be "good documentation", meaning she would ask for statements and inform the supervisor. LPN #1 acknowledged that no supervisor came to the assess Resident #51. LPN #1 stated she asked Resident #51 what

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

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F 610	Continued From page 31 happened, and the resident NJ Exec Order 26.4b1 what occurred. On 3/27/25 at 9:55 AM, the US FOIA (b) acknowledged that LPN #1 was not permitted to complete an assessment (outside the scope of practice for an LPN) and that there was no documentation that the Registered Nurse Supervisor investigated and assessed either Resident #51 or Resident #36 after the incident occurred on NJ Exec Order 26.4b1 An acceptable Removal Plan (RP) was received on 3/27/25 at 2:22 PM, which indicated the action the facility took to prevent serious harm from occurring or recurring. The facility implemented corrective action plan to remediate the deficient practice including; an amended Abuse Policy to ensure: staff involved with any NJ Exec Order 26.4b1 must remove the involved staff member immediately and that person must leave the clinical area, and not have further contact with residents until the investigation was completed, all other residents who are on the NJ Exec Order 26.4b1 assignment or have had contact with the NJ Exec Order 26.4b1 must be assessed and/or interviewed to ensure no NJ Exec Order 26.4b1 existed, a Supervisor or Manager must respond to all accidents and incidents in person to determine if the NJ Exec Order 26.4b1, and the Supervisor/Manager MUST call the US FOIA (b)(6) for all cases of NJ Exec Order 26.4b1 . On NJ Exec Order 26.4, Resident #51 and Resident #36 were assessed by the US FOIA (b)(6) to confirm NJ Exec Order 26.4b1 related to the NJ Exec Order 26.4b1 incident occurred; all nurse managers and supervisors would be required to respond to all reported incidents and accidents.	F 610		

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F 610	Continued From page 32 The survey team verified the implementation of the RP during the continuation of the on-site survey on on 3/28/25 at 9:20 AM.	F 610		
F 689 SS=E	NJAC 8:39-4.1(a)(5) Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of medical records and other facility documentation, it was determined that the facility failed to identify the causal factor and implement appropriate interventions to prevent recurrence and consistently follow [NJ Exec Order 26.4b1] interventions documented on the Care Plan. This deficient practice was identified for 1 of 2 residents (Resident # 76) reviewed for [NJ Ex Or] and [NJ Ex Order 26.4(b)(1)] and was evidenced by the following: On 3/24/25 at 9:49 AM, the surveyor observed Resident #76 in bed, the head of the bed was [NJ Exec Order 26.4b1] A [NJ Exec Order 26.] was observed on the [NJ Exec Order 26.4] of the bed and the call light and blanket were observed on the floor. The resident could not answer the surveyors questions. On 3/25/25 at 11:30 AM, the surveyor reviewed	F 689	Criteria #1 Review of all [NJ Exec O] sustained by resident #76 revealed that a new, appropriate intervention for each [NJ Exec] was not present on the resident's care plan and/or was not implemented as stated. Resident #76 care plan was reviewed by the Interdisciplinary Care Team and interventions were reviewed and updated to address interventions to attempt to [NJ Exec Order 26.4b1] and/or reduce the likelihood of [NJ Exec Orde] Criteria #2 Because all residents in our community could be affected by this deficient practice, the community reviewed the plan of care for active residents who have fallen in the last 90 days. The fall care	4/21/25

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F 689	Continued From page 33 the Admission Record which reflected that Resident #76 was admitted to the facility with diagnoses which included but were not limited to; NJ Exec Order 26.4b1 [redacted] On 03/27/25 at 9:48 AM, the surveyor again observed the call light, the phone was not within reach of the resident and alerted the staff. Resident was observed on the bed NJ Exec Order 26.4b1. The Quarterly Minimal Data Set (MDS) an assessment tool dated [redacted], reflected that Resident #76 had a BIMS (Brief Interview for Mental Status) score of [redacted] out of 15 indicative of NJ Exec Order 26.4b1 and had NJ Exec Order 26.4b1 due to the diagnoses of NJ Exec Order 26.4b1. The MDS also reflected that Resident #76 required total assistance of [redacted]. A review of the comprehensive care plan revealed that Resident #76 NJ Exec Order 26.4b1 at the facility. The care plan also reflected that Resident #76 was to have [redacted] on both [redacted] of the bed, phone on the bedside table, and personal items within reach. On 3/25/25 at 9:30 AM, the surveyor requested all investigations for Resident #76. On 3/26/25 the facility provided the following investigations which revealed the following [redacted] 1. On [redacted] at 10:24 AM, fell in the room. Upon inquiry, Resident #76 informed staff that they	F 689	plan was reviewed for appropriate intervention and found to be compliant for all like residents. Criteria #3 The community reviewed the plan of care for active residents who have fallen in the last 90 days. The fall care plan was reviewed for appropriate intervention and found to be compliant for all like residents. Criteria #4 Our Quality Assurance and Performance Improvement plan was revised under the direction of the Administrator to monitor compliant practice with identifying, documenting and reviewing appropriate interventions for each fall. We will review the Fall Risk care plan for 2 different residents each week for 6 weeks and then monthly for 2 months to ensure compliance is evident. Results of the observations will be reviewed at quarterly Quality Assurance and Performance Improvement meetings. The Quality Assurance and Performance Improvement committee will review outcomes and modify the plan as needed	

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F 689	Continued From page 34 were going to the bathroom. Intervention: Ask resident if they need to use the bathroom at the end of the shift. 2. On NJ Ex Order 26.4(b) at 4:50 PM, Resident #76 NJ Exec Order 26 of the NJ Exec O to the NJ Exec Orde Intervention: none were documented as implemented. 3. On NJ Ex Order 26.4(b) timed 9:49 PM, Resident #76 was NJ Exec Order 26.4b1 in their room calling for NJ Exec Ord Observed with NJ Exec Order 26.4b1 . Resident was transferred to the Emergency Department for evaluation. The intervention was to NJ Exec Order 26.4b1 as the resident NJ Exec Order 26.4b1 4. On NJ Ex Order 26.4(b) at 3:00 AM, observed on the NJ Exec O Intervention: was to ask the resident to call for assistance. 5. On NJ Ex Order 26.4(b) at 6:55 PM, fell NJ E the room while attempted to NJ Exec Order 26.4b1 Intervention: Ask the resident to call for assistance with NJ Exec Order 26.4b1 6. On NJ Ex Order 26.4(b) at 12:00 PM, Resident NJ Exec from the bed to the NJ Exec O while attempted to NJ Exec Orde for NJ Exec Order 26.4b1 on the NJ Exec Ord Intervention: Do not leave the resident in wheelchair NJ Exec Order 26.4b1 The resident NJ Exec Order 26.4b1 not while sitting in the chair. 7. On NJ Ex Order 26.4(b) at 11:35 PM, Resident #76 was NJ Exec Order 26.4b1 . The intervention was to have the NJ Exec Order 26.4b1 at bedside while resident was in bed.	F 689		

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F 689	Continued From page 35 8. On NJ Ex Order 26 at 8:20 PM, Resident #76 NJ Exec Order 26.4b1 [redacted]. Resident stated NJ Exec Order 26.4b1 and NJ Exec Order 26.4 on the floor. Interventions: Make rounds more often to ensure safety. 9. On NJ Ex Order 26.4(at 12:41 PM, Call light on, resident stated that they had to go to the bathroom. The resident had the light on at 9:00 and per the Certified Nurses Aide (CNA) was assisted to the bathroom at 9:00 AM. At 12:41 PM, resident was NJ Exec Order 26.4b to the bathroom and had a NJ Exec Order 2 [redacted]. Interventions: Hourly rounds for NJ Exec Order 26.4b1 care. 10. On NJ Ex Order 26.4 at 7:45 PM. The note reflected that Resident #76 informed the staff that they were trying to NJ Exec Order 26.4b1 [redacted]. The intervention was to have all personal items within reach. Place the phone on the bedside table. [The phone was not observed within reach on 3/27/25 at 9:47 AM]. 11. On NJ Ex Order 26.4(b) at 11:50 AM, NJ Exec Order 26.4b1 [redacted] Resident reported that they were trying to go to the bathroom, NJ Exec Order 26.4b1, rang the bell but nobody came. Interventions: Assist with NJ Exec Order 26.4 as per NJ Exec Order 26.4b1 recommendations. 12. On NJ Ex Order 26.4(at 9:50 AM, Resident #76 call light was on, CNA NJ Exec Orde the resident on the NJ Exec Order 26.4b1 [redacted] NJ Exec Order 26.4b1 [redacted] tervention: Assist resident in listening to audio books during room visits. 13. On NJ Ex Order 26.4(at 1:33 PM, CNA found Resident #76 on the NJ Exec Order 26.4b1 beside their bed in the room. Intervention: Assist resident with	F 689		

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F 689	Continued From page 36 NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 utilizing NJ Exec Order 26.4 recommendations. Determine resident's ability to NJ Exec Order 26.4b1 14. On NJ Ex Order 26.4(b) at 12:40 AM, Resident #76 was NJ Exec Order 26.4b1. There was no intervention for the NJ Exec Staff could not determine who assisted the resident to the bathroom or how long Resident #76 NJ Exec Order 26.4b1. 15. On NJ Ex Order 26.4(b) at 1:30 PM, Resident #76 NJ Exec from the NJ Exec Or while being NJ Exec Order 26.4b1 Intervention: Monitor and provide assistance with NJ Exec Order 26.4b1 if needed. 16. On NJ Ex Order 26.4(b)(1) at 10:25 PM, Resident #76 NJ Exec while being NJ Exec Order 26.4b1 by the CNA to the NJ Exec Orde Intervention: Use wheelchair when taking to the NJ Exec Order 26.4b1 17. On NJ Ex Order 26.4(b)(1) at 6:14 PM, Resident #76 NJ Exec while being NJ Exec Order 26.4b1 by the CNA. Intervention: Anticipate NJ Exec Order 26.4b1. Have all necessary items within reach. Give resident NJ Exec Order 26.4b1 before and during NJ Exec Order 26.4b1 18. On NJ Ex Order 26.4(b)(1) at 12:32 PM, Resident #76 was NJ Exec Order 26.4b1. Intervention: Remind resident to call for assistance. 19. On NJ Ex Order 26.4(b) at 7:01 PM, Resident #76 NJ Exec Orde Interventions: Have the resident wears NJ Exec Order 26.4b to NJ Exec Order 26.4b1. 20. On NJ Ex Order 26.4(b)(1) at 1:33 PM, resident NJ Exec Orde on the NJ Exec Order 26.4b1, NJ Exec Order 26.4b1 on. Resident stated they NJ Exec Order 26.4b1.	F 689		

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F 689	Continued From page 37 Intervention: Use NJ Exec Order 26.4b1 wheelchair/walker as needed. The incident report did not indicate when the resident was last [redacted] 21. On NJ Ex Order 26.4 at 8:50 PM, the US FOIA (b)(6) [redacted]) assisted Resident #76 to the bathroom, the resident NJ Exec Order 26.4b1 [redacted]. Intervention: Educate US FOIA to ask for assistance with NJ Exec Order 26.4 as part of the routine. 22. On NJ Ex Order 26.4 at 2:25 PM, during rounds the resident was NJ Exec Order 26.4b1 [redacted] Interventions NJ Exec Order 26.4b1 of the bed. 23. On NJ Ex Order 26.4(b) timed 11:05 PM, Resident #76 was NJ Exec Order 26.4b1 [redacted] in the room. Intervention: NJ Exec Orde bed to another wall away from the NJ Exec Order 26.4b 24. On NJ Ex Order 26.4(b) at 9:17 PM, US FOIA called and informed the staff that the residen NJ Exec Order 26.4b1 [redacted]. The US FOIA informed staff that the resident NJ Exec Order 26.4b1 [redacted]. Intervention: Frequent checks when family is visiting. 25. On NJ Ex Order 26.4(b) at 3:00 AM, observed the resident NJ Exec Order 26.4b1 [redacted]. Observed with a NJ Exec Order 26.4b1 [redacted]. The resident stated that they NJ Exec Intervention: Bedside table within reach. On 3/27/24 at 9:48 AM, the surveyor observed Resident #76 in bed, the call light was underneath the bed. The phone was on the dresser and was not within reach.	F 689		

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F 689	Continued From page 38 On 3/28/25 at 10:47 AM, the surveyor visited the resident, and observed the call light underneath the bed and the phone on the dresser. The phone was to be on the bedside table for easy reach. The surveyor accompanied the nurse to the room where we both observed the call light underneath the bed and the phone not within reach. The nurse told the surveyor that he was an agency staff and did not know much about the resident's routine. On 3/27/29 at 1:15 PM, the surveyor interviewed the US FOIA (b)(6)) regarding the NJ Exec Ord The US FOIA stated that Resident #76 NJ Exec Order 26.4 to get out of the bed and NJ Exec Order 26.4b1 unless they had an appointment. The US FOIA added that staff were to check on the resident frequently while in bed. On 3/27/25 at 1:35 PM, the surveyor discussed the NJ Exec O with the US FOIA (b)(6)) and asked for a timeline of the NJ Exec Ord On 03/28/25 at 10:47 AM, the surveyor observed Resident #76 in bed. The call light was observed underneath the bed, the phone was on the dresser and not on the bedside table, out of the resident's reach. On 03/28/25 at 9:41 AM, the survey team met with the US FOIA (b)(6) . The surveyor informed the US FOIA (b) and US FOIA (b)(6) of the observations regarding Resident #76 NJ Exec Order 26.4b1, observations of NJ Exec Order NJ Exec Order 26.4b1 related to NJ Exec Order 26.4 and a timeline of the NJ Exec O was requested. On 3/28/25 at 11:15 AM the US FOIA (b) stated that interventions were added on the care plan after	F 689		

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F 689	Continued From page 39 each [redacted] A review of the timeline provided failed to indicate that the causal factor was identified after each [redacted] and specific interventions were added to prevent recurrence. On 3/28/25 at 11:30 AM, the surveyor reviewed the facility policy titled, "Incident Reporting" revised 1/6/25. The policy indicated that "All accidents and incidents shall be investigated by the nurse on duty and/or Neighborhood Manager/Supervisor and documented in Risk Management (on the electronic medical record system). If the incident involves a resident fall, the fall investigation Worksheet should also be completed. Interventions based on the assessment of causal factors will be documented on the resident's care plan. NJAC 8:39-27.1 (a)	F 689		
F 712 SS=E	Physician Visits-Frequency/Timeliness/Alt NPP CFR(s): 483.30(c)(1)-(4) §483.30(c) Frequency of physician visits §483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. §483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. §483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally. §483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may	F 712		4/21/25

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F 712	Continued From page 40 alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to ensure that the physician responsible for supervising the care of residents conducted face to face visits, and documented progress notes at least every 60 days. This deficient practice was identified for 3 of 3 residents (Resident #8 and #22, #76) reviewed for physician care and was evidenced by the following: 1. On 3/22/25 at 10:30 AM, the surveyor observed Resident #8 in bed, the resident requested to speak with the surveyor. The resident informed the surveyor that they had not seen their assigned physician for NJ Exec Order 26.4b1. The resident stated that the US FOIA (b)(6) visited monthly for 5 minutes, and then charged for a 30 minute visit. The surveyor reviewed Resident #8's medical records. Resident #8 was admitted to the facility with diagnoses which included, but were not limited to; NJ Exec Order 26.4b1 A review of the Physician Progress Notes revealed that from NJ Exec Order 26.4b1 the US FOIA (b)(6) documented that she had seen Resident #8 and written the Progress Notes. NJ Exec Order 26.4b1 Review of the medical record revealed that the physician wrote a progress notes on	F 712	Criteria #1 Residents residing in a Long-Term Care Community must be seen by a physician at least once every 30 days for the first 90 days and after admission, at least once every 60 days thereafter, which can be achieved in collaboration with alternating visits by a Nurse Practitioner. Facility notified Medical Director of deficient practice who in turn ensured that a physician visit was made for resident #76 and resident #22 and appropriate documentation provided. Resident #8 no longer resides at the community. The individuals identified will be seen by the physician at least once every 60 days and at least once every 30 days thereafter in collaboration with Nurse Practitioner visits. Criteria #2 All residents have the potential to be affected by this deficient practice. A record review was completed for all current residents to ensure that residents have been seen by a physician with alternating visits with the Nurse Practitioner. The Medical Director will complete a physician visit for like residents on or before 4/21/25 Criteria #3 Under the direction of the Administrator and in cooperation with the community	

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F 712	Continued From page 41 NJ Exec Order 26.4. There was no documentation that Resident #8's primary physician had conducted alternating face to face visits with the resident while working in collaboration with the US FOIA (b)(6) [redacted]'s visits. 2. Resident #22 was had diagnoses which included but were not limited to; NJ Exec Order 26.4b1 [redacted]. A review of the Physician Progress Notes from NJ Exec Order 26.4b1 [redacted], reflected that the US FOIA (b)(6) [redacted] documented that she had seen Resident #22 almost weekly and written the following Progress Notes. A physician note was written NJ Exec Order 26.4b1. There was no documentation that Resident #22's primary physician had conducted NJ Exec Order 26.4b1 visits with the resident while working in collaboration with the US FOIA (b)(6) [redacted] visits. 3. Resident #76 was admitted to the facility with diagnosis which included, but were not limited to NJ Exec Order 26.4b1 [redacted]. A review of the Physician Progress Notes from NJ Exec Order 26.4b1 [redacted], reflected that the US FOIA (b)(6) [redacted] documented that she had seen Resident #76 almost weekly and documented Progress Notes. The physician completed the history and physical on NJ Exec Order 26.4b1 [redacted] and there was no documented physician progress notes in the clinical record regarding that the	F 712	Medical Director, a tracking system was developed to assist in ensuring alternating Physician/Nurse Practitioner Visits occur as indicated above. All Medical Providers were re-educated on the requirements of this regulation and expectations going forward. Criteria #4 Our Quality Assurance and Performance Improvement plan was developed under the direction of the Administrator to monitor compliant practice with required Physician and Nurse Practitioner alternating visit completion and documentation. We will review compliance with this on a monthly basis for 6 months to ensure provider visits meet the regulatory requirements. Results of the observations will be reviewed at quarterly Quality Assurance and Performance Improvement meetings. The Quality Assurance and Performance Improvement committee will review outcomes and modify the plan as needed.	

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F 712	Continued From page 42 physician NJ Exec Order 26.4b1 with the US FOIA (b)(6) [redacted] On 3/28/25 at 11:18 AM, the US FOIA (b)(6) [redacted] provided the facility policy titled, "Medical Service Physician Visits" last revised 10/30/2024. The following were documented: "A physician or advanced practice nurse shall visit each resident at least every 30 days. Following the initial visit, alternate 30-day visits may be delegated by physician to a Nurse Practitioner who possesses current licensure from the New Jersey State Board of Nursing in accordance with Home policy. Sick visits will be scheduled as needed". On 3/28/25 at 11:45 AM, the surveyor informed the US FOIA (b)(6) [redacted] regarding physician visits for Resident #8, #22 and #76. There was no additional information provided by the facility.	F 712		
F 808 SS=K	NJAC 8:39-27.1 Therapeutic Diet Prescribed by Physician CFR(s): 483.60(e)(1)(2) §483.60(e) Therapeutic Diets §483.60(e)(1) Therapeutic diets must be prescribed by the attending physician. §483.60(e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is not met as evidenced by: Complaint #: NJ 174543	F 808	Criteria #1	4/21/25

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	315166	A. BUILDING _____ B. WING _____	C 03/28/2025

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F 808	Continued From page 43 Repeat Deficiency Based on observation, interview, record review, and review of pertinent documentation, it was determined that the facility failed to ensure NJ Exec Order 26.4b1 were implemented for a NJ Exec Order 26.4b1 who was identified as being at NJ Exec Order 26.4b1 and required [redacted], did not receive a [redacted]. This deficient practice was identified for 1 of 2 residents review for [redacted] (Resident #3), and it was previously cited during a complaint visit. During a breakfast observation on 3/25/25, the surveyor observed Resident #3 in the NJ Exec Order 26.4b1 eating their meal and the resident began to NJ Exec Order 26.4b1. The surveyor observed Resident #3 had a half-filled plastic cup with a [redacted] inserted through the lid. At that time, the Licensed Practical Nurse (LPN #1) proceeded to the resident and removed the straw from the lid, and LPN #1 then approached the Certified Nurse Aide (CNA #1) to inform her that the resident could not have a [redacted]. An interview [redacted], with the US FOIA (b)(6)), revealed that Resident #3 had NJ Exec Order 26.4b1 had been discontinued because the resident "[redacted]" The facility's failure to ensure that a NJ Exec Order 26.4b1 resident with a special [redacted] instruction of "[redacted]" did not receive a [redacted]. Resident #3 was provided a [redacted] which posed the NJ Exec Order 26.4b1 which result in serious	F 808	During our annual recertification survey, a resident was observed with a plastic cup with a [redacted] inserted through the lid of the cup. This resident had a special [redacted] instruction stating "[redacted]" as a recommendation from the NJ Exec Order 26.4b1 to prevent NJ Exec Order 26.4b1. Upon being brought to our attention, the [redacted] was immediately removed and the Certified Nursing Assistant who provided the [redacted] was immediately re-educated on following all special instructions. Immediately following event nurse auscultated NJ Exec Order 26.4b1 for Resident #3. NJ Exec Order 26.4b1. On [redacted] at 9:30AM US FOIA (b)(6) [redacted] who provided the [redacted] to the resident was re-educated on the importance of reading everything on the [redacted] to ensure resident receives [redacted], adhering to any special instructions. On [redacted] at 9:30AM the nurse assigned to be in the [redacted] to monitor adherence to the meal ticket/instructions was re-educated on the importance of reading everything on the [redacted] to ensure resident receives correct [redacted] adhering to any special instructions. Nurse was re-educated on requirement to supervise the entirety of meal service and ensure items are checked before delivery to resident. All nursing and dining staff on duty today were re-educated on our policy of checking the [redacted] against what is being served to our residents. Emphasis was placed on the need to look at any printed special instructions. Anyone who	

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F 808	Continued From page 44 NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 or NJ Exec Order 26.4b1 This resulted in an Immediate Jeopardy (IJ) situation. The IJ began on NJ Exec Order 26.4b1 at 8:30 AM, when Resident #3 was observed NJ Exec Order 26.4b1 with a NJ Exec Order 26.4b1 in their NJ Exec Order 26.4b1 The facility's Administration were notified of the IJ on NJ Exec Order 26.4b1 at 2:54 PM. The facility submitted an acceptable Removal Plan (RP) on NJ Exec Order 26.4b1 at 11:31 AM. The survey team verified the implementation of the RP on-site on NJ Exec Order 26.4b1 at 9:20 AM. The evidence was as follows: A review of the facility provided policy "Thickened Liquids" dated 11/10/24, included but were not limited to; Residents with...altered-liquid consistency will receive thickened liquids at the level ordered...to safely maintain hydration. Purpose: to reduce or prevent the risk of aspiration. 6. Commercial thickened...juice will be provided for meal service and for nursing staff... A review of the facility provided policy "Checking Accuracy of Meal Tickets" dated 10/15/24, included but were not limited to; maintains a mechanism to ensure the safe and accurate...distribution of food items...Procedure: 6. Meals are placed on the counter for nursing to check for accuracy and special instructions... A review of the facility provided policy "Meal Service" dated 10/15/24, included but were not limited to; Procedures: B.10. A nurse will monitor the dining room during meals. C.3. Trained individuals will review the...diet slip...and serve the...beverages... On 3/25/25 at 8:30 AM, the surveyor observed	F 808	was not present today will need to be re-educated on this information before they will be allowed to serve residents. Our current meal audit tool was revised to include the need to document observed compliance with reviewing and following all special instructions. At 8:17PM Medical Director assessed resident. Orders for resident #3 were given and included chest NJ Exec Order 26.4b1 and every shift vitals for 3 days to monitor for signs and symptoms of NJ Exec Order 26.4b1 Criteria #2 Because all residents with a special dietary instruction could be affected by this deficient practice, the DON reviewed orders on 3/25/25 for all residents and found that no other resident had a special dietary instruction ordered. Criteria #3 Under the direction of the Director of Nursing and in cooperation with the community Administrator and Nurse Educator, provided education to all nursing staff regarding the importance of checking for and adhering to all special dietary instructions. Our current meal audit tool was revised to include the need to document observed compliance with reviewing and following all special instructions. Meal audits are completed at each meal by the nurse/designee. Criteria #4 Our Quality Assurance and Performance Improvement plan was revised under the direction of the Administrator to monitor	

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F 808	Continued From page 45 Resident #3 in the [NJ Exec Order 26.4b1] eating their meal who began to [NJ Exec Order 26.4b1]. The surveyor observed Resident #3 had a half-filled plastic cup with a [NJ Exec Order 26.4b1] through the lid. At that time, LPN #1 proceeded to the resident and removed the [NJ Exec Orde] from the lid. LPN #1 then approached CNA #1 and informed her that the resident could not [NJ Exec Order 26.4b1]. The surveyor observed the resident's meal ticket that was located next to the resident, and the ticket indicated Special Instructions: '[NJ Exec Order 26.4b1]" that was highlighted in [NJ Exec Order 26.4]. On 3/25/25 at 8:31 AM, the surveyor interviewed LPN #1, who stated that Resident #3 should not have any [NJ Exec Order 26]. On 3/25/25 at 8:32 AM, the surveyor interviewed CNA #1, who provided Resident #3 with the straw. CNA #1 stated she "was agency" (staff) and the process was that she was supposed to check the [NJ Exec Order 26.4b1], but she "did not see the ticket." CNA #1 stated, "I should have looked," and confirmed that she provided the [NJ Exec Orde] to Resident #3. On 3/25/25 at 8:35 AM, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM #1), who stated that the nurses and CNAs should check all [NJ Exec Order 26.4b1], and stated Resident #3 '[NJ Exec Order 26.4b1]." On 3/25/25 at 9:11 AM, the surveyor interviewed the [US FOO] who stated that Resident #3 had a [NJ Exec Order 26.4b1]) evaluation, and [NJ Exec Order 2] had been discontinued. The [US FO] stated the resident [NJ Exec Order 26.4b1]	F 808	compliant practice with following all special dietary instructions by observing for adherence to any special dietary instruction each meal for 30 days. Results of the meal audits and observations will be reviewed at quarterly Quality Assurance and Performance Improvement meetings. The Quality Assurance and Performance Improvement committee will review outcomes and modify the plan as needed until the goal of 100% compliance is achieved and committee determines that the problem is resolved or stable. Results will be used for training and system changes through the Quality Assurance and Performance Improvement committee.	

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F 808	Continued From page 46 On 3/25/25 at 9:30 AM, the surveyor interviewed the US FOIA (b)(6) , who stated the facility used agency staff, and the US FOIA (b)(6) educated agency staff on the facility's policies. The US FOIA (b)(6) stated, "I would have expected that NJ Exec Order 26.4b1 to have been caught prior to the resident receiving the NJ Exec Order 26. The US FOIA (b)(6) confirmed that per the prior Plan of Correction, the agency staff should have been educated. On 3/25/25 at 9:44 AM, the surveyor reviewed the electronic medical record for Resident #3. A review of the Admission Record face sheet (an admission summary), reflected that Resident #3 had diagnoses which included but were not limited to; NJ Exec Order 26.4b1). A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool dated NJ Exec Order 26. reflected a Brief Interview for Mental Status (BIMS) score of NJ Exe out of 15, which indicated the resident had a NJ Exec Order 26.4b1 A review of Section NJ Exec O for NJ Exec Order 26.4b1 reflected that Resident #3 was coded as NJ Exec which indicated the resident NJ Exec Order 26.4b1 or NJ Exec Order 26.4b1 . The MDS further documented that the resident received a NJ Exec Order 26.4b1 A review of the Order Summary Report reflected the following orders: a NJ Exec O order dated NJ Exec Order 26. , for NJ Exec Order 26.4b1 ; "acknowledge that appropriately ordered NJ Exec O was provided" and an order dated NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 evaluate	F 808		

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F 808	Continued From page 47	F 808		

and/or NJ Exec Order 26.4b1 .

A review of the individual comprehensive care plan (ICCP) included a focus area dated NJ Exec Order 26.4b and revised NJ Exec Order 26.4b1 that the resident was at NJ Exec Order 26.4b1 risk and had a NJ Exec Order 26.4b1 The goal was for the resident to NJ Exec Order 26 . One intervention included was to provide NJ Exec O as ordered, NJ Exec Order 26.4 NJ Exec Order 26.4b1 with NJ Exec Order 26.4b1 .

A review of the NJ Exec Order 26.4b1 Evaluation and Plan of Care note dated NJ Exec Order 26.4, included but was not limited to; NJ Exec Order 26.4b1 The reason for referral was that the resident NJ Exec Order 26.4b1 " Medical factors included NJ Exec Order 26.4b1 precautions.

A review of the NJ Exec Order 26.4b Significant Change Assessment note dated NJ Exec Order 26.4b, included but was not limited to; NJ Exec Order 26.4b1) with NJ Exec Order 26.4b1 . NJ Exec Order 26.4b1 ."

A review of the undated facility "Handbook" provided to agency staff included but were not limited to; Explanation of Diets... Dysphagia and why it is important: affects the muscle used for chewing and swallowing which become weak or uncoordinated. As a result, food and drink can go into the lungs instead of the stomach...can cause serious chest infections. Understanding and implementing the diet types are essential...to improve a resident's quality of life and address specific health challenges they may face. When a patient is not given the diet they are ordered one of three things may happen: 1) they may choke... 2) they may spend excess time chewing and may

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F 808	Continued From page 48 stop eating because they are tired resulting in weight loss, 3) they could aspirate leading to pneumonia or death... The acceptable Removal Plan on 3/27/25 at 11:31 AM, indicated the action the facility will take to prevent serious harm from occurring or reoccurring. The facility implemented a corrective action plan to remediate the deficient practice which included; on [redacted] at 8:30 AM, LPN #1 immediately removed the [redacted] from Resident #3's cup and explained to CNA #1 the resident's [redacted], the nurse auscultated ([redacted] for Resident #3 and their [redacted]; on [redacted] at 8:17 PM, the [redacted] assessed the resident, Resident #3 was ordered a [redacted] and vitals were ordered every shift for three days to monitor for signs and symptoms of [redacted] all nursing and dining staff were educated on the facility's policy for checking the [redacted] against what was being served to our residents with emphasis placed on the need to look at any printed special instructions. The survey team verified the implementation on-site during the continuation of the survey on 3/28/25.	F 808		
F 880 SS=E	NJAC 8:39-17.4(a)1; 27.1(a) Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the	F 880		4/21/25

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F 880	Continued From page 49 development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.	F 880		

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F 880	Continued From page 50 (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to a) ensure the infection control practices for residents on NJ Exec Order 26.4b1 [redacted] were implemented in accordance with accepted national standards, and b) ensure the facility's infection control for [redacted] policy reflected evidence-based standards of infection control practices. This deficient practice was identified for 3 of 3 residents reviewed on [redacted] (Resident #22, #8 and Resident #37 and was evidenced by the following: 1. On 3/21/25 at 10:14 AM, the surveyor observed a plastic bin with drawers outside the room for Resident #22. The drawers had personal protective equipment (PPE) including	F 880	Criteria #1 During our NJDHSS annual recertification survey, a C.N.A and a Nurse Practitioner were observed not adhering to posted NJ Exec Order 26.4b1 [redacted] sign instructions by not wearing appropriate PPE when entering a resident's room. An LPN was noted to be changing her gloves during a procedure appropriately but did not wash her hands in between glove changes. The same LPN failed to set up a clean field during a routine NJ Exec Order 26.4b1 [redacted] and then placed the NJ Exec Order 26.4b1 [redacted] directly on the bedside table. All staff involved in these lapses in following infection prevention practices were re-educated as soon as these concerns were brought to	

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F 880	Continued From page 51 gowns and gloves. A sign affixed to the resident's door indicated the following: NJ Exec Order 26.4b1 and specified the proper Personal Protective Equipment to wear prior to entering the room. On 3/24/25 at 9:05 AM, the surveyor observed a US FOIA (b)(6) in the room assisted Resident #22 with care. The US FOIA (b) was not wearing a PPE gown. The US FOIA (b) assisted Resident #22 with NJ Exec Order 26.4 and changed the bed linens. The US FOIA (b) washed her hands and exited the room. On 3/24/25 at 9:10 AM, the surveyor interviewed the US FOIA (b) who stated that she should have used the proper PPE when providing care. The US FOIA (b) added that the PPE was to be used when physical care, changing and cleaning was being performed. On 3/24/25 at 9:15 AM, the surveyor observed the US FOIA (b)(6)) caring for Resident #22's NJ Exec Order 26.4b1 The US FOIA (b) entered the room with the medication and the NJ Ex Order 26.4(b)(1), placed them on the bedside table, donned (put on) gloves, hung the NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1) and removed her soiled gloves. At 9:19 AM, the US FOIA (b) donned a pair of clean gloves, used an alcohol pad, disinfected the NJ Ex Order 26.4(b)(1) and removed her gloves. At 9:21 AM, the US FOIA (b) donned gloves removed the NJ Ex Or from the NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 to the NJ Exec Order 26.4b1. With the same gloved hands, the nurse adjusted the NJ Exec Order 26.4b1 to the NJ Exec Order 26.4b1 and ran the NJ Exec Order 26.4b1 . At 9:30 AM, the US FOIA (b) donned gloves,	F 880	our attention. Criteria #2 Because all residents could be affected by this deficient practice, rooms of all residents with current isolation precautions in place were audited to ensure the proper signage and PPE equipment was readily available for use. Reminder signs to wash hands between glove changes were placed on each nursing neighborhood. Criteria #3 To enhance currently compliant operations and under the direction of the Administrator and in cooperation with the community Infection Preventionist and Nurse Educator, all nursing staff will be re-educated on acceptable Infection Prevention and Control practices, emphasizing the need to ensure use of appropriate PPE equipment and on setting up a clean field for dressing changes with proper disposal of used dressings. A review of proper hand hygiene was included. Criteria #4 Our QAPI plan was revised under the direction of the Administrator to monitor compliant practice with utilizing appropriate PPE for applicable interactions with residents and/or their environment, proper handwashing between glove changes, the establishment of a clean field on which to place items needed for dressing changes and proper disposal of soiled dressings.	

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F 880	Continued From page 52 adjusted the NJ Exec Order 26.4b1 and placed the NJ Exec Orde [redacted]. At 9:33 AM, the US FOIA (failed to wash hands and then used Alcohol Based Hand Rub prior to exiting the room. On 3/26/25 at 11:55 AM, the surveyor interviewed the US FOIA (regarding the observed procedure. The US FOIA (confirmed that she should wash her hands after removing her gloves because it was the protocol. The US FOIA (stated, "I did not do it yesterday." When asked what was the recommended hand hygiene for residents on NJ Exec Order 26.4b1, she stated, "soap and water". On 3/26/25 at 12:45 PM, the surveyor discussed the above observation with the US FOIA (b)(6) [redacted] The US F confirmed that staff had received in-service education regarding NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1. The US F stated confirmed that during care for Resident #22 staff should wear the proper PPE and wash their hands after removing their gloves. The US F confirmed that Resident #22 had an infection called NJ Exec Order 26.4b1 [redacted] Resident #22 was also on NJ Exec Order 26.4b1 [redacted]. Resident #22 had also a NJ Exec Order 26.4b1 and the PPE was only necessary when physical contact rendering care was being performed. A review of Resident #22's Face Sheet (admission summary) indicated Resident #22 was admitted to the facility on NJ Exec Order 26.4 and readmitted NJ Exec Order 26.4b1 with diagnoses which included NJ Ex Order 2 NJ Exec Order 26.4b1	F 880	We will interview 1 nurse and 1 C.N.A. on each Neighborhood each day for 2 weeks, asking them to answer questions related to each of the practices listed above. We will record their responses and re-educate on the spot as needed. Those same staff members will be asked to demonstrate proper handwashing. We will also conduct weekly dressing change audits for 3 months. Results of the observations will be reviewed at quarterly QAPI meetings. The QAPI committee will review outcomes and modify the plan as needed.	

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 03/28/2025

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 880	Continued From page 53 NJ Exec Order 26.4b1 [redacted].	F 880		

A review of the resident's electronic physician's order dated [redacted] indicated the [redacted] was ordered to treat the [redacted]

A review of the resident's electronic Care Plan initiated [redacted], indicated Resident #22 was on NJ Exec Order 26.4b1 [redacted]) while [redacted] was in place. The interventions included for staff to maintain standards [redacted] Hand washing before and after each intervention.

2. On 3/24/25 at 10:46 AM, the surveyor observed the same [redacted] cleansing the [redacted] site for Resident # 44. The [redacted] failed to set a clean field for the procedure. The [redacted] donned gloves, removed the [redacted] and placed it on the bedside table. The then [redacted] donned gloves, cleansed the [redacted] of the bedside table. The [redacted] did not change her soiled gloves after removing the [redacted]. The [redacted] disinfected the table prior to exiting the room, and used ABHR to disinfect her hands.

On 3/26/25 at 12:45 PM, the concern was discussed wit the [redacted] The [redacted] confirmed that the nurse should have had a clean field and should not have placed the [redacted] on the resident over bed table.

On 3/28/25 at 11:27 AM, the survey team met with the [redacted]

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	315166	A. BUILDING _____ B. WING _____	C 03/28/2025

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

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F 880	Continued From page 54 ([redacted]) The [redacted] stated that the concerns were brought to her attention and the staff was reeducated. A review of the facility policy for Enhanced Barriers Precautions, dated 4/1/24 revealed the following: Enhanced Barriers precautions are used as an infection control prevention and control interventions to reduce the spread of multi-drug resistant organisms (MDROs) to residents. EBP employ targeted gown and gloves use during high contact resident care activity when contact precautions do not otherwise apply. Example of high contact resident care including: dressing, changing linens, device care or use (central line, urinary catheter..) EPB are indicated for residents infected or colonized with ESBL, Vancomycin-resistant Enterococci. . Section D of the policy under Types of Precautions to be used if isolation required: indicated the following under "Hand Hygiene" When hands are visibly dirty, contaminated or soiled, hands are to be washed with soap and water. If caring for a resident with C. difficile, or Norovirus, do not use alcohol based hand-rubs; instead wash hands with soap and water. The policy further indicated that hands are to be washed before resident contact, before putting on gloves or other PPE. Before initiating residents treatments. 3. On 3/21/25 at 9:29 AM, during the initial tour, the surveyor observed two signs on Resident #37's door. The signs were as follow: [redacted]	F 880		

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 03/28/2025

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 880	Continued From page 55	F 880		

NJ Exec Order 26.4b1 and sequence for putting on Personal Protective Equipment (PPE; clothing and equipment that is worn or used in order to provide protection against hazardous substances or environments). The surveyor observed that the NJ Exec Order 26.4b1 sign indicated "Everyone must: Clean their hands, including before entering and when leaving the room. Providers and staff must also: Put on gloves before room entry. Put on gown before room entry." The surveyor observed a PPE bin with gowns and gloves at the doorway. The surveyor observed a [redacted] who transported a breakfast tray to Resident #37's room and was wearing a N95 mask before entering into Resident #37's room. The [redacted] was not observed wearing a PPE gown and gloves as the sign on the resident's door indicated that was to be worn before entering into the room. The surveyor observed the [redacted] exit the resident's room and the [redacted] did not perform hand hygiene upon exiting the room. The [redacted] walked to the [redacted] area (a casual dining space where they offer meals and snacks) and retrieved food for the resident in a cup and walked back into Resident #37's room. The [redacted] was not observed performing hand hygiene, when donning the gown and gloves prior to entering the room. The [redacted] then assisted the resident to cut their food.

At 9:34 AM, upon exiting Resident #37's room, the surveyor conducted an interview with the [redacted] The [redacted] informed the surveyor that she was an agency [redacted] and it was her third time working at the facility. The [redacted] informed the surveyor that the resident was on [redacted] for [redacted] in their [redacted] The [redacted] further stated

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	315166	A. BUILDING _____ B. WING _____	C 03/28/2025

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 880	Continued From page 56 she knew if the resident was on NJ Exec Order 26.4b [redacted], she had to put on gown, gloves and mask before entering the resident's room. The US FOIA (b) [redacted] stated that she just brought breakfast for the resident, so she did not have to put on gown and gloves because she was not providing care to the resident. On 3/21/25 at 9:42 AM, during an interview with the surveyor, the US FOIA (b)(6) [redacted] stated the resident had a NJ Exec Order 26.4b1 [redacted]) and was on NJ Exec Order 26.4b [redacted] NJ Exec Order 26 [redacted]]) and NJ Exec Order 26.4b1 [redacted].) in NJ Exec Orde[redacted] The US FOIA (b)(6) [redacted] stated the staff had to wear a gown, gloves and masks anytime when they entered the resident's room. The surveyor informed the above-mentioned observations for Resident #37 to the US FOIA (b)(6) [redacted] acknowledged that the US FOIA (b) [redacted] should have put on PPE before entering the resident's room for infection control. On 3/21/25 at 9:49 AM, the surveyor observed the US FOIA (b)(6) [redacted]) going into Resident #37's room. The US FOIA [redacted] was not observed wearing a gown and gloves before entering the room. The US FOIA [redacted] performed hand hygiene after exiting the room. At 9:53 AM, during an interview with the surveyor, the US FOIA [redacted] stated she was seeing the resident for the first time. The US FOIA [redacted] acknowledged that she did not	F 880		

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MASONIC VILLAGE AT BURLINGTON	902 JACKSONVILLE ROAD BURLINGTON, NJ 08016

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F 880	Continued From page 57	F 880		

see the NJ Exec Order 26.4b1 signage on the door. The [redacted] pointed towards the PPE bin at the doorway and further stated, "this been an indication to put PPE, but I guess I went in the room too fast."

At 10:08 AM, they surveyor informed the US FOIA (b)(6) about the above-mentioned observations. The US FOIA (b)(6) stated the staff should be donning the gown and gloves when going into Resident #37's room. The US FOIA (b)(6) further stated that PPE rule applied to everyone going into the room.

At 10:15 AM, the survey team met with the US FOIA (b)(6) [redacted]). The surveyor notified of the above-mentioned concerns. The US FOIA (b) stated, "it was a concern" and further stated the US FOIA (b) and the [redacted] were pulled-off of the floor and were sent for education. The US FOIA (b) acknowledged that the staff did not follow facility policy by not donning PPE before entering into the NJ Exec Order 26.4b1 .

At 1:07 PM, during an interview, the US FOIA (b)(6) [redacted] stated the staff should have put PPE on before entering into resident's room because of resident's history of NJ Exec Order 26.4b1

On 3/25/25 at 10:08 AM, the surveyor reviewed the medical records for Resident #37 which revealed the following:

The Admission Record (AR, admission summary) reflected that the resident was admitted to the facility, had diagnoses which included but were not limited t NJ Exec Order 26.4b1 [redacted]

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 03/28/2025

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

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F 880	Continued From page 58 The Annual Minimum Data Set (MDS), a resident assessment tool used by the facility to prioritize care, dated NJ Exec Order 26.4b1, revealed that Resident #37 scored NJ Ex out of 15 on their Brief Interview for Mental Status (BIMS), which indicated the resident had a NJ Exec Order 26.4b1. The NJ Ex Order 26.4(b)(1) Physician Order Summary (POS) Report indicated a physician order, dated NJ Exec Order 26.4 for NJ Exec Order 26.4b1 related to NJ Exec Order 26.4b1 every shift. On 3/28/25 at 9:42 AM, the survey team met with the US FOIA (b)(6) to present concerns. On 3/28/25 at 11:15 AM, the US FOIA (b)(6) was notified of the above-mentioned concerns via telephone. The US FOIA acknowledged that "it was definitely a concern" when the US FOIA went into a NJ Exec Order 26.4b1 resident's room and was not observed wearing PPE (gown and gloves). A review of facility provided undated "Isolation Procedures", included: D.2.b. Transmission-Based Precautions are to be used in conjunction with Standard Precautions. The 3 basic categories are: a. These precautions are used to stop spread of bacteria via direct contact such as skin to skin contact and indirect contact such as person making contact with contaminated objects such as bed, call bells,.. etc. b. gloves and gowns are to be worn when making contact with resident's skin or with objects that have been in direct contact with the resident. E.4. CDC's (Center for disease control) recommendations for preventing transmission of ..., VRE, ESBLs, consists of Standard	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MASONIC VILLAGE AT BURLINGTON	**902 JACKSONVILLE ROAD BURLINGTON, NJ 08016**

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F 880	Continued From page 59 Precautions which are used for all resident care as well as Contact Precautions. d. Wear gloves when caring for resident. e. Wear gown during care of resident. NJAC 8:39-19.4(1,2), 27.1(a)	F 880		

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
	030306	A. BUILDING: _____ B. WING _____	C 03/28/2025

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) COMPLETE DATE
S 000	Initial Comments Complaint #s: NJ 174543, NJ 174805, NJ 179076 Survey Date: 3/21/25 through 3/28/25 Census: 113 Sample: 25 + 1 Closed Record The facility is not in compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities based on this complaint survey.	S 000		
S2315	8:39-31.6(i)(1-2) Mandatory Physical Environment (i) The administrator shall serve as, or appoint, a disaster planner for the facility. 1. The disaster planner shall meet with county and municipal emergency management coordinators at least once each year to review and update the written comprehensive evacuation plan, or if county or municipal officials are unavailable for this purpose, the facility shall notify the State Office of Emergency Management. 2. While developing the facility's evacuation plan, the disaster planner shall coordinate with the facility or facilities designated to receive relocated residents.	S2315		4/21/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 04/21/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	030306	A. BUILDING: _____ B. WING _____	C 03/28/2025

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

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S2315	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review and interview on 3/27/25 in the presence of the Administrator, it was determined the facility failed to meet with county and municipal emergency management coordinators at least once each year to review and update the written comprehensive evacuation plan, or if county or municipal officials are unavailable for this purpose, notify the State Office of Emergency Management. This deficient practice had the potential to affect all residents and was evidenced by the following: A record review of the facility's Emergency Preparedness (EP) manual and annual review sign off sheet revealed no record of the state or county and municipal Office of Emergency Management (OEM) officials participating in the annual review. In an interview at 3:30 PM, the surveyor had explained the requirement and asked the Administrator for documentation of an invitation to participate or participation in the annual review of the emergency evacuation plan by county and municipal OEM officials or notification to the State OEM. The Administrator stated the facility did not invite the county and municipal OEM officials to review the evacuation plan in the past year. The facility's Administrator and the Director of Facilities Services were informed of the deficient practice at the Life Safety Code exit conference at 3:47 PM.	S2315	Criteria #1 It was determined that our community failed to meet with county and municipal emergency management coordinators or the state Office of Emergency Management annually to review and update the written comprehensive evacuation plan. Once brought to our attention, we provided our plan to County Office of Emergency Management and sought feedback because all residents could be affected by this deficient practice. Criteria #2 Because all residents could be affected by this deficient practice and to ensure ongoing compliance, a schedule was created, and email reminder notification set up to ensure an annual meeting going forward will occur. Criteria #3 The Director of Facilities Services/designee will Inservice all Facility Services staff regarding this required review. The Executive Director and Administrator/Quality Assurance and Performance Improvement Coordinator was informed of proposed schedule going forward. Criteria #4 Our Quality Assurance and Performance Improvement plan was revised under the direction of the Administrator in cooperation with the Facility Services Director/Designee to monitor compliant practice with the required annual review of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	030306	A. BUILDING: _____ B. WING _____	C 03/28/2025

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S2315	Continued From page 2	S2315	our comprehensive evacuation plan with County and Municipal Emergency Management Coordinators or the state Office of Emergency Management. Results of the observations will be reviewed at quarterly Quality Assurance and Performance Improvement meetings.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315166 Y1	A. Building B. Wing Y2	5/23/2025 Y3

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 F0808 Reg. # 483.60(e)(1)(2) LSC	Correction Completed 04/21/2025	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 3/28/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315166 Y1	A. Building B. Wing Y2	5/23/2025 Y3

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

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0600	Correction	ID Prefix F0610	Correction	ID Prefix F0689	Correction
Reg. # 483.12(a)(1)	Completed	Reg. # 483.12(c)(2)-(4)	Completed	Reg. # 483.25(d)(1)(2)	Completed
LSC	04/21/2025	LSC	04/21/2025	LSC	04/21/2025
ID Prefix F0712	Correction	ID Prefix F0808	Correction	ID Prefix F0880	Correction
Reg. # 483.30(c)(1)-(4)	Completed	Reg. # 483.60(e)(1)(2)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed
LSC	04/21/2025	LSC	04/21/2025	LSC	04/21/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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	
3/28/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
030306 Y1	A. Building B. Wing Y2	5/23/2025 Y3

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 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 S2315 Reg. # 8:39-31.6(i)(1-2) LSC	Correction Completed 04/21/2025	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
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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 3/28/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

 EVENT ID: K7I512

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 _____	**03/28/2025**

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
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		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 03/25/25, 3/26/25 and 3/27/25. Masonic Village at Burlington was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. Masonic Village at Burlington is a three story Type II protected constructed building that was built in January 2004. The facility is divided into 8 smoke zones. The facility had 264 licensed beds and 113 beds were occupied at the time of survey.	K 000		
K 211 SS=E	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1	K 211		4/21/25

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

Electronically Signed | 04/21/2025

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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K 211	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 3/26/25 in the presence of the US FOIA (b)(6) [redacted], it was determined the facility failed to ensure means of egress at exit discharge were continuously maintained free of all obstructions to full use in case of emergency in accordance with NFPA 101: 2012 Edition, Section 7.1.10.1. This deficient practice had the potential to affect 18 residents and was evidenced by the following: An observation at 10:08 AM of the exit discharge out of the exit Stair Tower 16-3 at ground level, revealed a wooden ramp approximately 4-foot by 4-foot and 8-inches high at the door that sloped to ground level. When the Surveyor stepped out onto the ramp his foot went through the plywood demonstrating the wood material was deteriorated and not adequate for egress travel. In an interview at the time, the US FOIA (b) [redacted] confirmed the observation. The facility's US FOIA (b)(6) [redacted] were informed of the deficient practice at the Life Safety Code exit conference on 3/27/25 at 3:47 PM. N.J.A.C. 8:39-31.1(c), 31.2 (e)	K 211	Criteria #1 Surveyor identified a wooden ramp at the exit of stair tower 16-3 was found to be deteriorated and not adequate for egress travel. The wooden ramp was removed immediately. Criteria #2 To ensure compliance with all other exit doors, a sweep of the building revealed one other wooden ramp in place. That ramp was removed as well. Criteria #3 To enhance currently compliant operations, inspections of all exterior doors was added to facility services weekly door inspection log and all Facility Services team members were educated on this requirement. Criteria #4 Our QAPI plan was revised under the direction of the Executive Director and in coordination with the Director of Facility Services/Designee to monitor compliant practice with daily required exterior door inspections by reviewing the Facility Services log book for completion and findings once a week for 2 months. Results of the observations will be reviewed at quarterly QAPI meetings.	
K 225 SS=E	Stairways and Smokeproof Enclosures CFR(s): NFPA 101 Stairways and Smokeproof Enclosures	K 225		4/21/25

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K 225	Continued From page 2 Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 This REQUIREMENT is not met as evidenced by: Based on observation and interview in the presence of the US FOIA (b)(6) [redacted], it was determined the facility failed to ensure stairwells and fire proof enclosures used as vertical exits were protected by doors that self-close and positive latch in accordance with NFPA 101: 2012 Edition, Section 7.2.1.8, 8.3.3 to 8.3.4.4, 19.2.2.3, 19.2.2.4 and NFPA 80: 2010 Edition. This deficient practice had the potential to affect 24 residents and was evidenced by the following: An observation at 11:41 AM of Stair Tower 30-0 / N2 basement level fire door, revealed the door did not close all the way into its frame and positive latch when fully opened and released. The door stopped at the edge of the door frame when tested. In an interview at the time, the US FOIA (b) [redacted] confirmed the observation. The facility's US FOIA (b)(6) [redacted] were informed of the deficient practice at the Life Safety Code exit conference on 3/27/25 at 3:47 PM. N.J.A.C. 8:39-31.1(c), 31.2 (e) NFPA 80	K 225	Criteria #1 Upon inspection, stair tower 30-0 N2 basement fire door did not fully self-close and latch. When brought to our attention, the door strike was adjusted with confirmation that the door now self-closes fully and the latch fully engages. This deficient practice had the potential to affect 24 residents Criteria #2 This deficient practice had the potential to affect 24 residents. Because all fire doors could be affected by this deficient practice, all doors were checked to ensure proper self-closure and positive latching. No other issues were found. Criteria #3 To enhance currently compliant operations, a logbook to record the routine scheduled checking of all fire doors was reviewed and updated. This requirement was reviewed with the Facility Services department team members including who would be responsible for completing this check weekly. Criteria #4 Our QAPI plan was revised under the	

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K 225	Continued From page 3	K 225	direction of the Executive Director in coordination with the Director of Facility Services/Designee to monitor compliant practice with required fire door self-closure/positive latch test on all fire doors by reviewing the logbook of recorded checks weekly for 2 months and then monthly thereafter to ensure all are found to be properly functioning or if not, that appropriate action was taken. Results of the observations will be reviewed at quarterly QAPI meetings.	
K 321 SS=F	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons)	K 321		4/21/25

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K 321	Continued From page 4 e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 3/25/25 in the presence of the US FOIA (b)(6) [redacted], it was determined the facility failed to ensure hazardous area doors were self-closing and positively latching in accordance with NFPA 101: 2012 Edition, Section 19.3.2.1. This deficient practice had the potential to affect all residents and was evidenced by the following: 1. An observation at 11:30 AM of trash room N27/055 revealed the room door to the corridor did not latch when tested. 2. An observation at 11:32 AM of mechanical room N28 double doors revealed the door did not close all the way into its frame. The door leaf with the strike on it hit the leaf with the strike plate on it and stopped at the leading edge. 3. An observation at 12:02 PM of the basement central supply room double doors revealed the door did not close all the way into its frame when tested. When the left door leaf was closed and the right leaf was opened and allowed to close, the right leaf strike hit the left leaf and stopped at the leading edge. The room was approximately 50-foot by 70-foot and contained boxes of combustible storage. In interviews at the times, the [redacted] confirmed the observations.	K 321	Criteria #1 Upon inspection, it was found that 3 doors to identified hazardous areas were not self-closing and positively latching. Our Facilities Management Team have adjusted those 3 doors to ensure positive self-closing and latching. This deficient practice had the potential to affect all residents Criteria #2 This deficient practice had the potential to affect all residents. Because all hazardous area doors have the potential to be affected by this deficient practice, all hazardous area doors were tested and found to be compliant. Criteria #3 To enhance currently compliant operations, the Door Inspections log was updated to record positive self-closure and latching of all hazardous area doors. This requirement was reviewed with the Facility Services department team members including who would be responsible for completing this check weekly. Criteria #4 Our QAPI plan was revised under the	

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K 321	Continued From page 5 The Facility's US FOIA (b)(6) were informed of the deficient practice at the Life Safety Code exit conference on 3/27/25 at 3:47 PM. N.J.A.C. 8:39-31.2 (e)	K 321	direction of the Executive Director in coordination with the Director of Facility Services/Designee to monitor compliant practice with required fire door self-closure/positive latch test on all fire doors by reviewing the logbook of recorded checks weekly for 2 months and then monthly thereafter to ensure all are found to be properly functioning or if not, that appropriate action was taken. Results of the observations will be reviewed at quarterly QAPI meetings.	
K 324 SS=F	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2	K 324		4/21/25

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K 324	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review on 3/26/27 in the presence of the Director of [redacted], it was determined the facility failed to ensure the Monthly Owners Inspection was performed on 2 of 2 range-hood wet chemical fire suppression systems in accordance with NFPA 17A: 2009 Edition, Section 7.2, 7.2.1 to 7.2.6. This deficient practice had the potential to affect all residents and was evidenced by the following: Observations at 9:55 AM of the 2 kitchen range-hood wet chemical fire suppression system inspection tags revealed the last semiannual inspections were performed on December 2024. Further review showed the back of the cards monthly inspection rows and columns were blank. No other records were provided. In interviews at the time, the [redacted] confirmed the observations. The facility's [redacted] were informed of the deficient practice at the Life Safety Code exit conference on 3/27/25 at 3:47 PM. N.J.A.C. 8:39-31.2 (e) NFPA 17A, 96	K 324	Criteria #1 Upon inspection, it was found that 2 kitchen range hood wet chemical fire suppression system inspection tags lacked documentation to confirm semi-annual inspections were performed. The tags for both range hoods were updated to document inspection dates. Criteria #2 Because all fire suppression system inspection tags could be affected by this deficient practice, all were checked, and their tags were found to show compliance with semi-annual checks. This includes all fire suppression checks and fire extinguisher checks. Criteria #3 To enhance currently compliant operations, the importance of all fire suppression system inspection tags being thoroughly completed with each semi-annual inspection was reviewed with all Facility Services team members. Criteria #4 Our QAPI plan was revised under the direction of the Executive Director in coordination with the Director of Facility Services/Designee to monitor compliant practice with semi-annual checks of kitchen range hood wet chemical fire suppression systems with subsequent	

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K 324	Continued From page 7	K 324	inspection tags completion monthly for one year to ensure the semi-annual inspections occurred and that the inspection tags were completed and revealed compliance. Results of the observations will be reviewed at quarterly QAPI meetings.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review on 3/25/25/, 3/26/25 and 3/27/25 in the presence of the US FOIA (b)(6) [redacted] it was determined the facility failed to ensure fire sprinkler systems and their components were inspected tested and maintained in accordance with NFPA 101: 2012	K 353	Criteria #1 On inspection, the following was found: 1. One dry pipe fire sprinkler system with no documentation that a 3-year Air Leak Test was performed as required. 2. Outside the launderette in the basement corridor there were two 4-inch	4/21/25

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K 353	Continued From page 8 Edition, Section 9.7 and NFPA 25: 2011 Edition. This deficient practice had the potential to affect all residents and was evidenced by the following: 1. A record review on 3/26/25 from 11:55 AM to 3:30 PM revealed there was a dry pipe fire sprinkler system and there was no documentation that a 3 year Air Leak Test was performed as required by 25:13.4.4.2.9. In an interview on 3/27/25 at 11:57 AM, the [redacted] confirmed the record review. 2. Observations during a facility tour on 3/25/25 from 10:00 AM to 3:25 PM revealed: a) In the basement corridor outside the launderette there were two 4-inch metal conduit pipes penetrating through the drop ceiling smoke barrier with open space around them. Penetrations in monolithic ceiling membranes designed with fire sprinkler heads in the plane of the ceiling, allow smoke and hot gasses to pass through the membrane barrier into the space above impeding the proper operation of the sprinkler. b) In mechanical room #2, the drop ceiling tiles were missing in 5 locations. c) In storage room #011, two of 2 sprinkler heads were coming down 2-inches. d) In storage room #0/3, two of 2 sprinkler heads were coming down 2-inches. e) In the basement data storage room, a 2-foot by 3-foot ceiling tile was missing where the data	K 353	metal conduit pipes penetrating through the drop ceiling smoke barrier with open space around them. 3. Mechanical Room #2 were missing drop ceiling tiles 4. Storage Room #011 had 2 sprinkler heads down 2 inches 5. Storage Room #0/3 had 2 sprinkler heads down 2 inches 6. Basement Data Storage Room, a ceiling tile was missing 7. Data Storage Closet #N20/051 had drop ceiling tiles missing and a sprinkler head in the plane of the grid 8. Storage Room S37/044 had 3 sprinkler heads with no escutcheons 9. Elevator Room S9/006C had a ceiling tile missing 10. Room 378C had 1 sprinkler head with ¿ space around it 11. Stair tower 28-2 there was 2 sprinkler escutcheons coming down ¿ inches from the ceiling 12. Room 321 F, there were 8 penetrations for wires and conduit through the drop ceiling with space around them and 1 sprinkle head had no escutcheon 13. Data Rooms 306 C and 156 C had unsealed penetrations for wires in drop ceilings 14. Room 152 C had two 4-inch water pipes penetrating the drop ceiling with space around them 15. Ceiling by Room 152 had a sprinkler head missing its escutcheon 16. Kitchen Dry Storage Room had 1 sprinkler head missing its escutcheon. All outlined items above were	

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K 353	Continued From page 9 wires penetrated into the space above. f) In data closet #N20/ 051, the drop ceiling had no tiles in the ceiling grid and had a sprinkler head in the plane of the grid. g) In storage room S37/ 044, three of 3 sprinkler heads had no escutcheons. h) In elevator room S9/ 006C, there was a 2-foot by 2-foot ceiling tile missing by sprinkler and smoke detector. i) In room 378 C, there was 1 sprinkler head with a 1/2-inch by 2-inch space on the side. j) In stair tower 28-2, one of 2 sprinkler escutcheons were coming down 3/4 of an inch from ceiling. k) In room 321 F, there were 8 penetrations for wires and conduit through the drop ceiling with space around them and 1 sprinkler head had no escutcheon. l) In data rooms 306C and 156C, there were unsealed penetrations for wires in the drop ceilings. m) In room 152 C, there were two 4-inch water pipes penetrating the drop ceiling with space around them. n) In the corridor ceiling by room 152 the sprinkler head was missing its escutcheon. o) In the kitchen dry storage room, one of 7 sprinkler heads was missing its escutcheon.	K 353	repaired/rectified by our Facility Services Team Members with the exception of #s 1,4, and 5 above which will be correct by 4/21/25.This deficient practice had the potential to affect all residents Criteria #2 This deficient practice had the potential to affect all residents.Because all sprinkler heads and ceiling areas could be affected by this deficient practice, a thorough check of all sprinkler heads was completed by Facility Services and vendor and all ceiling areas were inspected by the Facility Services team to look for additional sprinkler head or penetration concerns. None were found. Criteria #3 The schedule of routine audits of all sprinkler heads was reviewed with our vendor and will commence with checks quarterly to ensure all sprinkler heads are maintained properly. The Facility Services team will be notified of any construction, renovation or other service that is performed that effects the integrity of the ceiling so that they may check to ensure no penetrations exists. A log of these notifications with subsequent inspections and status of findings with documented remedies will be maintained. Criteria #4 Our QAPI plan was revised under the direction of the Executive Director in coordination with the Director of Facility Services/Designee to monitor compliant	

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K 353	Continued From page 10 In interviews at the times, the US FOIA (b) confirmed the observations and record review. The facility's US FOIA (b)(6) were informed of the deficient practice at the Life Safety Code exit conference on 3/27/25 at 3:47 PM. N.J.A.C. 8:39-31.2 (e) NFPA 13, 25	K 353	practice with sprinkler head checks and the log of activity involving potential damage to the integrity of ceiling tiles with subsequent penetration areas. Our sprinkler head vendor documentation will be reviewed quarterly. The log of construction, renovation or other service events that are performed that could potentially affect the integrity of the ceiling will be reviewed weekly x4 weeks then monthly to ensure an inspection was performed and any concerns addressed. Results of the observations will be reviewed at quarterly QAPI meetings.	
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or	K 363		4/21/25

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	315166	A. BUILDING 01 B. WING _____	03/28/2025

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

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K 363	Continued From page 11 pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observations and interview on 3/25/25 in the presence of the US FOIA (b)(6) [redacted] it was determined the facility failed to ensure corridor doors positively latched in accordance with NFPA 101: 2012 Edition, Section 19.3.6.3 and 19.3.6.3.5(1). This deficient practice had the potential to affect 6 residents and was evidenced by the following: An observation at 1:00 PM revealed nurses lounge room 385D corridor door did not latch when tested because it had paper material stuffed in the strike hole on the door frame. An observation at 3:10 PM revealed resident room 142 corridor door did not latch when tested. In interviews at the times, the [redacted] confirmed the observations. The facility's U.S. FOIA (b) (6) and the [redacted] were	K 363	Criteria #1 On inspection, it was found that Nurses lounge room 385 D corridor door did not latch when tested because paper material had been stuffed in the strike hole on the door frame. Also, Room 142 corridor door did not latch when tested. The paper material was removed from door 385 D strike hole and room 142 door was adjusted to allow the door to self-latch.This deficient practice had the potential to affect 6 residents Criteria #2 This deficient practice had the potential to affect 6 residents. Because all corridor doors have the potential to be affected by this deficient practice, every door was checked for proper positive latching. All other doors were found to be compliant.	

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K 363	Continued From page 12 informed of the deficient practice at the Life Safety Code exit conference on 3/27/25 at 3:47 PM. N.J.A.C. 8:39-31.2 (e)	K 363	Criteria #3 To enhance currently compliant operations, all corridor doors will be checked weekly to ensure positive self-closing and latching. A log of these inspections will be maintained. The Facility Services Team and nursing staff will be educated on these scheduled inspections and person(s) accountable will be identified. Criteria #4 Our QAPI plan was revised under the direction of the Executive Director in coordination with the Director of Facility Services/Designee to monitor compliant practice with required corridor door self-closure/positive latch test on all corridor doors by reviewing the logbook of recorded checks monthly for 6 months and then quarterly thereafter to ensure all are found to be properly functioning or if not, that appropriate action was taken. Results of the observations will be reviewed at quarterly QAPI meetings.	
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke	K 372		4/21/25

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MASONIC VILLAGE AT BURLINGTON	**902 JACKSONVILLE ROAD** **BURLINGTON, NJ 08016**

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K 372	Continued From page 13 barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 3/26/25 in the presence of the US FOIA (b)(6) [redacted] it was determined the facility failed to ensure penetrations through a smoke partition were protected by a system or material capable of limiting the transfer of smoke for 3 of 4 barrier walls observed in accordance with NFPA 101: 2012 Edition, Section 8.4 and 8.5.6. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 10:37 AM of the concealed space above the double smoke doors by room 339, revealed there were 4 places where wires were penetrating through openings in the sheet rock and concrete barrier wall. An observation at 10:55 AM of the concealed space above the double smoke doors by room 310, revealed a sheetrock wall barrier that met a concrete wall approximately 18-inches above the drop ceiling. The steel framed sheet rock wall did not come all the way up to the concrete wall and left a space that varied from 2 to 6-inches and was opened all the way through the barrier across the width of the hallway. On the lounge side of the corridor, there was an opening in the sheet rock approximately 5-inches by 12-inches with multiple wires penetrating through. Along the course of the barrier from right to left there were wire, pipe and conduit penetrations. An observation at 11:10 AM of the concealed	K 372	Criteria #1 On inspection, the following was found: 1. The space above the double smoke doors by room 339 revealed 4 places where wires were penetrating through openings in the sheetrock and concrete barrier wall. 2. The concealed space above the double smoke doors by room 310 revealed a sheetrock wall barrier with various penetration areas across the hallway 3. The concealed space above double smoke doors by room 133 revealed 2 places where there were openings with penetrations. This deficient practice had the potential to affect all residents. All the above areas have been addressed by the Facility Services Team and are currently compliant. Criteria #2 This deficient practice had the potential to affect all residents. All smoke door ceiling areas have the potential to be affected by this deficient practice, a thorough inspection of all smoke door ceiling areas was performed by our facility services team to ensure no further penetrations exist. All areas were found to be compliant.	

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K 372	Continued From page 14 space above double smoke doors by room 133 revealed 2 places where there were through wall openings with pipe and wire penetrations. In interviews at the times, the [US FOIA] confirmed the observations. The facility's [US FOIA (b)(6)] were informed of the deficient practice at the Life Safety Code exit conference on 3/27/25 at 3:47 PM. N.J.A.C. 8:39-31.2 (e)	K 372	Criteria #3 The Facility Services team will track any construction, renovation or other service that is performed that effects the integrity of the ceiling so that they may check to ensure no penetrations exists. A construction log was created to identify construction projects with subsequent inspections and status of findings with documented remedies. All facility service team members were educated on the deficiency and process for compliance. Criteria #4 Our QAPI plan was revised under the direction of the Executive Director in coordination with the Director of Facility Services/Designee to monitor compliant practice and subsequent logging of construction, renovation or other service events that are performed that could potentially affect the integrity of the ceiling. This log will be reviewed weekly to ensure an inspection was performed and any concerns addressed. All smoke door ceiling areas will be checked monthly for 3 months to ensure compliance with the logging of any construction, renovation or other services performed that could potentially affect the integrity of the ceiling. Review of documentation of remedies of any concerns found will also be included. The QAPI committee will review outcomes at monthly meetings and modify the plan as needed until the goal of 100% compliance is achieved and committee determines that the problem is resolved or stable	

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K 541 SS=E	Rubbish Chutes, Incinerators, and Laundry Chu CFR(s): NFPA 101 Rubbish Chutes, Incinerators, and Laundry Chutes 2012 EXISTING (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1-hour. All new chutes shall comply with 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4. (Existing laundry chutes permitted to discharge into same room are protected by automatic sprinklers in accordance with 19.3.5.9 or 19.3.5.7.) (4) Existing fuel-fed incinerators shall be sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 3/26/25 in the presence of the US FOIA (b)(6) [redacted] it was determined the facility failed to ensure rubbish chute doors latched when closed in accordance with NFPA 101: 2012 Edition, Section 9.5, 19.5.4 and NFPA 82: 2009 Edition. This deficient practice had the potential to affect 12 residents and was evidenced by the following: Observations at 2:53 PM of trash room 152D	K 541	Criteria #1 On inspection, it was found that trash room 152 D had a vertical rubbish chute that had a fire rated door that did not positive latch when tested. Upon notification, the Facility Services staff repaired this latch. This deficient practice had the potential to affect 12 residents Criteria #2 This deficient practice had the potential to	4/21/25

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K 541	Continued From page 16 revealed a vertical rubbish chute serving 3 floors and the basement that had a fire rated door that did not positive latch when tested. In an interview at the time, the [redacted] confirmed the observation. The facility's [redacted] were informed of the deficient practice at the Life Safety Code exit conference on 3/27/25 at 3:47 PM. N.J.A.C. 8:39-31.2 (e)	K 541	affect 12 residents. Because all rubbish and laundry chutes have a potential to be affected by this deficient practice, all doors were checked to ensure positive latch occurred when tested. All were found to be compliant. Criteria #3 To enhance currently compliant operations, all rubbish and laundry chute doors will be checked monthly to ensure positive self-closing and latching. A log of these inspections will be maintained. The Facility Services Team will be educated on these scheduled inspections and person(s) accountable will be identified. Criteria #4 Our QAPI plan was revised under the direction of the Executive Director in coordination with the Director of Facility Services/Designee to monitor compliant practice with required rubbish and laundry chute door self-closure/positive latch tests on all applicable doors by reviewing the logbook of recorded checks monthly for 6 months and then quarterly thereafter to ensure all are found to be properly functioning or if not, that appropriate action was taken. Results of the observations will be reviewed at quarterly QAPI meetings.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing	K 918		4/21/25

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K 918	Continued From page 17 The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on interview and record review on 3/25/25, 3/26/25 and 3/27/25, in the presence of the US FOIA (b)(6) it was determined the facility failed to: 1. exercise the diesel powered generators at 30% or greater of	K 918	Criteria #1 On inspection, it was found that our community failed to show proof of: 1. Exercise of the diesel-powered generators at 30% or greater of their	

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K 918	Continued From page 18 their name plate rating during the monthly full load tests or conduct a 90 minute annual load bank test for 2 of 2 diesel generators, 2. check and record the transfer time from the primary power source to the secondary power source during the full load test each month to demonstrate the transfer time is 10 seconds or less for 2 of 2 diesel generators and 3. exercise the two diesel generators for 4 continuous hours or conduct a 4 hour load bank test every 36 months, in accordance with NFPA 99: 2012 Edition and NFPA 110: 2010 Edition. These deficient practices had the potential to affect all residents and were evidenced by the following: A documentation review on 3/25/25 of the facility's generator log and inspection, testing and maintenance reports revealed: 1. The percent of the nameplate rating for the available load during the monthly load tests were not observed, determined or recorded and a 90 minute annual load bank test was not performed if the generators load was less than 30% of the nameplate rating for the last 12 months on both of the facility's generators. 2. There was no power transfer time recorded on the generator logs for the 400 kilowatt (kW) and 275 kW generators for each of the monthly load tests in the past 12 months. 3. The last time the 400 and 275 kW diesel generators were exercised for 4 continuous hours or a 4 hour load bank test was conducted in the last 36 months was dated 7/13/2021 and 7/26/2021 respectively. July 2021 is over 43 months ago and 7 and a half months past their due date.	K 918	name plate rating during the monthly full load tests or conduct a 90-minute annual load bank test for 2 diesel generators. 2. Check and record the transfer time from the primary power source to the secondary power source. 3. Exercise the two diesel generators for 4 continuous hours or conduct a 4-hour load bank test every 36 months All residents have the potential to be affected by this deficient practice. Both generators were immediately inspected and found to be safely and properly functioning. The 3-year 4 continuous hours of full load run time was completed for both generators 3/31/25. Community vendor confirmed a exercise of the diesel-powered generators at 30% or greater of nameplate rating will occur monthly. The community will manually record transfer time from the primary power source to the secondary power source with monthly full load generator test. Criteria #2 All residents have the potential to be affected by this deficient practice. Because all generators could be affected by this deficient practice, all were inspected and found to be safely and properly functioning. Criteria #3 The facility logbook was reviewed to ensure documentation of weekly generator inspections. A schedule for on-going inspections was developed.	

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K 918	Continued From page 19 In interviews on 3/27/25 at 12:10 PM and 1:31 PM, the [US FOIA (b)] confirmed the record review. The [US FOIA (b)] stated that what the contracted service did, is what the facility has for the generators. The [US FOIA (b)] also stated the load bank test was on a 4 year schedule with the contractor and will be changed to every 3 years. The facility's [US FOIA (b)(6)] were informed of the deficient practice at the Life Safety Code exit conference on 3/27/25 at 3:47 PM. N.J.A.C. 8:39-31.2 (e), 31.2(g) NFPA 99, 110	K 918	Facility will work with Vendor to ensure confirmation of documentation of 30% or greater name plate rating during monthly full load test. The community will manually record transfer time from the primary power source to the secondary power source with monthly full load generator test in a log. 3-year generator test added to work order schedule. All Facility Services team members were educated on this important task and the schedule to be followed going forward. Criteria #4 Our QAPI plan was revised under the direction of the Executive Director in coordination with the Director of Facility Services/Designee to monitor compliant practice with required generator checks by auditing the logs for compliance with the completion of the inspections and for proper follow up if necessary on a monthly basis. Results of the observations will be reviewed at quarterly QAPI meetings.	
K 923 SS=F	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing	K 923		4/21/25

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K 923	Continued From page 20 gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations and interview on 3/25/25 in the presence of the US FOIA (b)(6) [redacted], it was determined the facility failed to ensure empty oxygen cylinders are segregated from full cylinders and oxygen were separated from combustibles accordance with NFPA 99: 2012 Edition, Section 11.6.5.2, 11.6.5.2.1, 11.6.5.3, 11.3 and 11.3.2.3(2). This deficient practice had the potential to affect all residents and was evidenced by the following:	K 923	Criteria #1 On inspection, the following was found: 1. 6 designated oxygen storage rooms were observed with empty canisters not segregated from full canisters and while the gauge on each canister measured the amount of oxygen remaining in the tank, there were no markings on the cylinders or signs indicating which cylinders were full or empty. 2. NJ Exec Order 26.4b1 had combustible boxes	

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K 923	Continued From page 21 Observations during a facility tour between 10:00 AM and 3:25 PM revealed: 1. In 6 of 6 designated oxygen storage rooms observed, empty oxygen E-cylinders were not segregated from full cylinders. There were no markings on the cylinders or signs indicating which cylinders were full or empty. The room numbers were identified as NJ Exec Order 26.4b1 [redacted] 2. In 2 of 6 sprinkler protected oxygen storage rooms observed, combustibles were stored with in 5-feet of the E-oxygen cylinders. Room [redacted] had combustible boxes and bags on a countertop next to the oxygen storage rack with E tanks. Room [redacted] had a 5 shelf storage rack full of combustible diapers 2-feet from the tank rack. In interviews at the times, the [redacted] confirmed the observations. The facility's US FOIA (b)(6) [redacted] were informed of the deficient practice at the Life Safety Code exit conference on 3/27/25 at 3:47 PM. N.J.A.C. 8:39-31.2 (e) NFPA 99	K 923	and bags on a countertop next to and less than 5 feet from the oxygen storage rack and NJ Exec Order 26.4b1 [redacted] had a 5-shelf storage rack with combustible diapers on it that was only 2 feet from the tanks. Because all residents have the potential to be affected by this deficient practice, oxygen cylinders in the 6 designated oxygen storage rooms were immediately tagged with empty/full tags to be used to indicate the status of each tank. Rooms have been designated for full oxygen canisters and empty oxygen canisters. All combustible material corrected to ensure material is greater than 5 feet from oxygen storage rack. Criteria #2 All residents have the potential to be affected by this deficient practice. Because all oxygen storage rooms could be affected by this deficient practice, all six rooms were checked to ensure all tanks were tagged and segregated appropriately and that no combustible items were found less than 5 feet away from the crate of cylinders. All were found to be compliant. Criteria #3 A log was developed on which to document weekly oxygen room inspections. All nursing staff, facility services team members and the purchasing manager were all in serviced on oxygen storage requirements and the proper use of full/empty oxygen cylinder tags.	

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 _____	**03/28/2025**

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

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K 923	Continued From page 22	K 923	Criteria #4 Our QAPI plan was revised under the direction of the Executive Director in coordination with the Director of Facility Services/Designee to monitor compliant practice with required storage and tagging of oxygen tanks, auditing of logs and each oxygen storage room for compliance will be performed weekly for 4 weeks and then monthly for 6 months to ensure compliant practice. The Manager of Central Supply/designee will be responsible for these checks. Results of the observations will be reviewed at quarterly QAPI meetings.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315166 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	5/23/2025 Y3

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	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0211	04/21/2025	LSC K0225	04/21/2025	LSC K0321	04/21/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0324	04/21/2025	LSC K0353	04/21/2025	LSC K0363	04/21/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0372	04/21/2025	LSC K0541	04/21/2025	LSC K0918	04/21/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0923	04/21/2025	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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 3/28/2025

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO