

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

PRINTED: 03/04/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315166	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/22/2024
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NAME OF PROVIDER OR SUPPLIER MASONIC VILLAGE AT BURLINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 902 JACKSONVILLE ROAD BURLINGTON, NJ 08016
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	<p>INITIAL COMMENTS</p> <p>Complaint #: NJ168631</p> <p>Census: 115</p> <p>Sample Size: 3</p> <p>THE FACILITY IS IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.</p>	F 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 09/17/2024
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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.

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 030306	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/22/2024
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NAME OF PROVIDER OR SUPPLIER MASONIC VILLAGE AT BURLINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 902 JACKSONVILLE ROAD BURLINGTON, NJ 08016
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S 000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long-Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on review of pertinent facility documentation, it was determined that the facility failed to ensure staffing ratios were met to maintain the required minimum staff-to-resident ratios as mandated by the state of New Jersey for 1 of 14 evening shifts. The deficient practice was evidenced by the following: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified as N.J.S.A. 30:13-18 (the Act), which	S 560	Criteria #1 At Masonic Village of Burlington, it is our goal to provide excellent care consistent with established nursing standards. We pride ourselves on following all State and Local Regulations. While conducting a survey, four (4) weeks of staffing numbers were requested by the surveyor. Upon review of that submitted data, the surveyor found that 1 out of 84 shifts revealed a lower number of C.N.A.s than State Regulations require. Upon learning of this, we reviewed all time and staffing sheets for the requested time frames to ensure that that the proper number of staff to meet and/or exceed the minimum	9/27/24

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

Electronically Signed

TITLE

(X6) DATE

09/17/24

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 030306	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/22/2024
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S 560	<p>Continued From page 1</p> <p>established minimum staffing requirements in nursing homes. The following ratio (s) were effective on 02/01/2021:</p> <p>One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer of all staff members shall be CNAs and each direct staff member shall be signed into work as a certified nurse aide and shall perform nurse aide duties: and one direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties.</p> <p>The surveyor requested staffing for the weeks of 10/08/2023 to 10/21/2023, the facility was deficient in CNAs to total staff on 1 of 14 evening shifts as follows:</p> <p>-10/11/23 had 7 CNAs to 18 total staff on the evening shift, required at least 9 CNAs.</p>	S 560	<p>requirements was in place.</p> <p>Criteria #2 Because all residents could be affected by this deficient practice, staffing numbers per shift were reviewed for a full 3-month period and at no time were there less than the required number of staff working at Masonic Village at Burlington. We will continue to review our staffing levels on a shift to shift basis to ensure we are meeting or exceeding the required ratios.</p> <p>Criteria #3 To enhance currently compliant operations and under the direction of the Director of Nursing and in cooperation with the community Administrator, we will continue to take great care to ensure the correct and accurate data is recorded in all required and requested documents. Copies of the submitted Nursing Home Resident Care Staffing Report will be attached to daily staffing sheets for reference and a spread sheet was developed to monitor daily staffing ratios.</p> <p>Criteria #4 Our QAPI plan was revised under the direction of the Administrator to monitor compliant practice with required staffing ratios and accurate documentation of such. We will review our staffing ratios for the next 6 weeks on a daily basis to ensure each shift of each day meets or exceeds the regulatory requirements and that all numbers recorded accurately reflect the numbers of staff at work each shift of each day.</p>	

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S 560	Continued From page 2	S 560	Results of the observations will be reviewed at quarterly QAPI meetings.	

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 030306	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 9/27/2024
NAME OF FACILITY MASONIC VILLAGE AT BURLINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 902 JACKSONVILLE ROAD BURLINGTON, NJ 08016	

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____	09/27/2024	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 _____	
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 <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 8/22/2024
 CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
 YES NO