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	06/30/2023

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 45209 Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to a.) clarify and accurately transcribe a physician's order for an enema (a medication used to relieve constipation); b.) document the administration of the enema; c.) obtain physician's orders in accordance with professional standards of practice for tube feeding for the flushing of water before and after medication pass and checking residual to ensure accountability and consistency. The deficient practice was identified for 2 of 20 residents reviewed for professional standards of practice (Resident #43 and #778) and was evidenced by the following: Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board The nurse practice act for the State of New Jersey states; The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist. Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist. 1. On 6/21/23 at 10:23 AM, the surveyor observed Resident #43 sitting in their chair eating breakfast. At this time, Resident #43 advised that they were admitted to the facility on a Thursday and went back to the hospital that Saturday for a bowel impaction. The resident reported to the surveyor that they informed the facility upon admission they have not had a bowel movement and was told that it was a result of the pain medication. The surveyor reviewed the medical record for Resident #43. A review of the Admission Record face sheet (an admission summary) reflected the resident was admitted to the facility in May of 2023, with diagnoses which included closed fracture of the left hip. (continued on next page)

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.

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the admission Minimum Data Set (MDS), an assessment tool dated 5/17/23, reflected a brief interview for mental status (BIMS) score of 15 out of 15, which indicated a fully intact cognition. A review of the Physician Progress Notes included a note dated 5/5/23 at 9:18 AM, that indicated no [bowel movement] since 4/29 give enema (medication used for constipation) [one time] today. The note did not include if the enema was administered. A review of the May 2023 Physician Summary Report did not include the one time order for the enema ordered by the Physician on 5/5/23. A review of the corresponding May 2023 Treatment Administration Record (TAR) and Medication Administration Record (MAR) did not include the administration of the enema on 5/5/23 or 5/6/23. On 6/26/23 at 10:24 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) who confirmed that the nurses were responsible for putting in physician orders. On 6/25/23 at 12:47 PM, the surveyor interviewed Unit Manager/Licensed Practical Nurse (UM/LPN #1) who confirmed there was documentation that the order for the enema was entered, reconciled, or even that the order was relayed to the nurse and administered. When asked who had the responsibility for transcribing physician orders, the UM/LPN #1 stated everyone had the responsibility to make sure orders were transcribed. On 6/26/23 at 1:38 PM, the surveyor interviewed the Director of Nursing (DON) who confirmed that there was no documentation that the order for the enema was carried out. When asked who had the responsibility for transcribing physicians orders the DON stated, the nurse that is assigned typically. On 6/28/23 at 10:40 AM, the Licensed Nursing Home Administrator (LNHA) in the presence of the DON, stated that the resident received the enema on 5/5/23, as ordered by the Physician, but the nurse forgot to input the physician order into the medical record as well as document the administration of the enema. The LNHA further stated that she spoke to the resident who confirmed the enema was administered as ordered, as well as the resident requested to be transferred to the hospital instead of receiving a second enema on 5/6/23. On 6/30/23 at 9:30 AM, LNHA in the presence of the DON, Administrator in Training, and survey team confirmed that the nurse who received the verbal order was responsible for putting into the medical record. The LNHA continued anytime a verbal order was taken it should be documented, input on the MAR and TAR, and documented as administered. A review the facility's Telephone and Verbal Orders policy dated 1/5/21 and last reviewed on 1/9/23, included .2. Verbal orders are those given by an authorized practitioner directly to a person authorized to receive and transcribe order on his or her behalf. 4. The individual receiving the verbal order must write it on the physicians order sheet as v.o. (verbal order) or t.o. 43308 (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. On 6/22/23 at 9:30 AM, the surveyor observed Resident #778 lying in bed watching television and who stated that he/she was doing okay, and everything was fine. At that time, Licensed Practical Nurse (LPN #1) informed the surveyor and the resident that the tube feeding was completed and would go back up at 3:00 PM. LPN #1 then took down the empty bottle of Jevity 1.5 (nutrition formula); and placed a clean white towel on top of the resident's abdomen near the feeding tube (FT; tube inserted into the stomach for nutrition) to prevent any leakage. LPN #1 took out her stethoscope and used a disinfectant wipe to clean it. She informed the resident she was going to listen for the placement of the FT. She then used a syringe and checked the gastric residual volume. She then informed the resident she was going to administer the medication gabapentin (treat seizures and nerve pain) 300 milligrams (mg). LPN #1 grabbed a four ounce (4 oz) plastic cup filled with water and poured some of the water down the FT and informed the resident she was flushing the FT with water. She then administered the gabapentin crushed mixed with water into the FT. LPN #1 then grabbed the 4 oz plastic cup again and poured some more water into the FT. LPN #1 stated that she was flushing with water again. She then informed the resident she was going to change her gown and gloves to change the FT dressing. The surveyor reviewed the medical record for Resident #778. A review of the Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility June of 2023, with diagnoses which included dysphagia (difficulty swallowing) and gastro-esophageal reflux disease (GERD; stomach acid back flow into esophagus). A review of the Order Summary Report (OSR) for June 2023 included the following physician's orders (PO) for enteral feeding (feeding tube): A PO dated 6/16/23, to administer Jevity 1.5 at a rate of 75 milliliter per hour (75 mL/hr) for twenty hours for a total volume of 1500 mL; hang up at 3:00 PM. A PO dated 6/16/23, to administer a water flush of 250 mL of water every six hours. The OSR did not in PO for the checking of residual as observed by LPN #1 or the water flush administered with medication administration. A review of the individualized comprehensive care plan (ICCP) included a focus area initiated 6/16/23, that the resident was at nutritional risk as evidenced by diagnosis of chronic obstructive pulmonary disease, GERD, dysphagia, and FT regimen. Interventions included to monitor gastric residuals (the amount of liquid drained from a stomach following administration of enteral feed) after each scheduled feeding as resident will allow and to administer Jevity 1.5 at a rate of 75 mL/hr for a total volume of 1500 mL with 250 mL water flushes every six hours. The ICCP did not include the amount of residual to monitor for or to notify the physician of a certain amount of residual. The ICCP also did not include the water flushes observed during medication administration. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/23/23 at 10:41 AM, the surveyor interviewed LPN #1 who stated that the process for tube feeding included performing hand hygiene, putting on a pair of gloves, using a syringe to check the residual and the placement which was a physician's order (PO). She then stated that the nurses flushed the FT with water with the amount specified in the PO which was given before and after each medication. She stated that if the medication was appropriate to be crushed, it would be mixed with water and flushed again with the ordered amount of water. LPN #1 stated that she believed there was a PO in the electronic medical record (EMR) as she thought she signed off on it. She further stated it would have to be a PO to show it was done. On 6/23/23 at 10:44 AM, LPN #1 and the surveyor reviewed the EMR together. LPN #1 stated that there were orders to flush 250 mL of water every six hours and for the Jevity 1.5 at 75 mL/hour for 20 hours only. LPN #1 confirmed the EMR did not include a PO for how much water to flush between medications, for monitoring the residual, and checking the placement. LPN #1 stated that the residual and placement she just did automatically. At that time, LPN #1 continued to review the EMR and confirmed she did not see any active orders or discontinued orders for water flushes before and after medications, monitoring the residual, and checking the placement. LPN #1 stated that there should be orders for the water flushes before and after medication administration, monitoring the residual, and checking the placement. LPN #1 stated that it was important to ensure the nurses were not over flushing the resident and gave the ordered amount of water, in addition to checking for placement to ensure the FT was in the proper place, and the residual to ensure the resident was appropriately digesting the feeding. On 6/23/23 at 10:54 AM, the surveyor interviewed UM/LPN #2 who stated that the process for tube feeding included to ensure the tubing was patent (unobstructive). UM/LPN #2 stated that they flushed with 10 mL of water before and after each medication. She further stated that the nurse had to first check placement as you want to hear a whoosh sound that assured the tube was in place. UM/LPN #2 stated you then checked for any residual to ensure the feeding was working. She confirmed a PO was needed to check residual and placement as well as for water flushes before and after a medication. She stated that it was important to ensure there were POs for these to ensure the tubing was functioning like it was supposed to. She further stated that the POs were important so everyone knew what to do for that resident. UM/LPN #2 emphasized you have an order for everything. The surveyor continued to review the medical record. A further review of the OSR after surveyor inquiry revealed the following after surveyor inquiry: A PO dated 6/23/23, to check placement of the FT before beginning a feeding and before administering medications. Notify MD if placement is not confirmed every shift. A PO dated 6/23/23, to flush FT with 30 mL warm water prior to all medication administrations to check correct placement of tube every shift. The PO did not include to administer water flushes after medication administration or between each medication. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/23/23 at 12:18 PM, UM/LPN #2 stated in the presence of the survey team, that the facility followed the [company's name redacted] manual for new hires which was located on each nursing unit. She stated that all of the unit managers had one, and that the facility conducted in-services when things changed and provided the surveyor with in-service conducted on 5/22/23 to 5/29/23. UM/LPN #2 acknowledged that there should have been orders for water flushes before and after medication administration and checking the residual. UM/LPN #2 confirmed she had entered the PO in the EMR after surveyor inquiry. On 6/26/23 at 10:55 AM, the surveyor interviewed the DON who stated that the process for tube feeding included that they referred to the facility's policy and procedures in following the steps. She stated that the steps included checking for placement, checking for residual, and flushing the tube with 30 mL to 60 mL of water before and after the mediation administration. She then stated that you would mix the medication in water and ensure it was thin enough to be administered through the feeding tube. She further stated that they used gravity to administer the medications, but occasionally they would push with a 60 mL syringe if needed. The DON again stated they referred to the policies and some of it was simply nursing judgement as we all learned it in nursing school. She further stated unless it was something different than normal or unexpected, then they needed an order such as if the resident was on a fluid restriction or different quality of gastrointestinal issues. When asked would you need a physician's order for checking the placement, checking the residual, and flushes before and after the administration of medication? The DON stated, it would be a good reminder to have an order, but I would expect the nurses to know the standard of practice with feeding tubes. She again stated she would not expect to have a physician's order for the water flushes before and after medications; checking the residual and placement as that was all a standard of practice. On 6/26/23 at 11:04 AM, the surveyor asked the DON about UM/LPN #2 entering a physician's order after surveyor inquire. The DON stated after the surveyor talked to UM/LPN #2, they thought that moving forward it would be good to add those orders in and to show it was done. On 6/26/23 at 11:27 AM, the surveyor interviewed the LNHA who stated that physicians had to provide orders for anything that we are doing to the residents. The surveyor asked did they need a physician's order for the checking the placement of the FT, checking the residual of the FT, and water flushes before and after medication administration with a FT. The LNHA stated that if they deemed necessary, they would obtain a physician's orders but that it was nursing standard of practice to make sure they were checking the placement and that it was intact, flushing the tube checking for patency and checking the residual to ensure we are not over feeding the resident and they are tolerating the feeding. The LNHA emphasized that they just considered that checking placement, checking residual and flushes before and after medication as nursing standard of practices and did not need a physician's order. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/27/23 at 11:26 AM, the surveyor interviewed the Medical Director (MD) via telephone who stated that the nursing staff should be following the protocol for tube feedings which included checking the placement, checking the gastric residual, and flushing the tube. He stated that it was important to follow the protocol as it would let the physician know if the resident tolerated the feeding, the placement to ensure it was not dislodged, and the flushes to ensure it was not clogged. He further stated following those protocols ensured there were no issues with the tube. When asked was a physician's order required, the MD replied that he was not sure if a PO was needed. The MD again stated it was important to know and follow the protocol. The MD stated that for the free water flushes, there should be a PO. He further stated that the POs varied from each resident based on their needs when it came to the flushes. The MD then stated that the flushes before and after medication was a small amount of 10 to 20 mL to ensure the tube was not clogged. When asked was an order required for the before and after medications, the MD again stated he was not sure if a PO was needed as that was a nursing practice. He further stated that checking for placement and residual was part of the examination, and when they documented it that would be their accountability. The MD concluded everyone worked together for the care of the resident. The surveyor asked for clarification on if a PO was needed to ensure there was accountability, and the MD was unable to provide clarification. On 6/27/23 at 11:37 AM, the surveyor interviewed the DON again who stated if it was not in a PO, then they did not have to document to ensure accountability. The DON stated, as professional nurses we need to make the assumption that it is getting done and that there needs to be an understanding that the nurses are doing the job they are trained for. The DON confirmed that if care was not documented then there would be no way to ensure accountability. She then stated that if a resident on was on fluid restrictions, then there would a PO for the specific amount, but a resident was not on fluid restrictions then they would base it off their policy which indicated to flush the tube with 30 to 60 mL before and after medications. The DON emphasized I would hope they are following the policy. She then stated that if a resident was not on fluid restrictions, then they would not be concerned about tracking the fluid amount. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/28/23 at 9:33 AM, the surveyor interviewed the Consultant Pharmacist (CP) via the telephone who stated that she was out on leave for three months, and it was her first week back. She stated that prior to her leave, she had the nurses complete an in-service on tube feedings she thought in January or February of 2023. The surveyor continued to interview the CP regarding residents that required tube feedings. The CP stated that if a resident was on a tube feed, she looked to ensure that there were actual orders of tube feeding as well as water flushes. She further stated that some facility had orders for flushes 30 mL before and after medications with a minimal of five (5) mL between each medication being administered. The CP stated that it was standard of practice to flush the tube with 30 mL before and after medication administration and should be reflected in the facilities' policies. The CP stated that based on her understanding, some facilities did not require an order because it was considered a standard of practice. She stated that during her in-service, she informed her nurses to flush the tube before and after medication administration with the 30 mL of water unless the resident was on fluid restrictions. The CP further stated that if there was no specific order for it, then they should be following the protocol standard of practice for checking the placement, checking the residual and the flushes. The CP then stated that it would be best practice if they had an order to ensure accountability but again stated that not all facilities required to have orders in place for the standard of practice. The CP stated, it would be nice to have those orders in place. The CP stated she did not discuss a lot with the nurses regarding tube feed as the facility did not have a lot of residents on tube feedings. The CP stated that if there was not a PO, then there would be no way to ensure accountability. The CP acknowledged there should be a way to ensure accountability in a form of a PO or documentation regarding the checking of the placement, residual and flushes. At that time, the CP was unable to speak on any additional information and stated that there should be some type of way to ensure accountability. On 06/28/23 at 10:03 AM, the surveyor interviewed the Registered Dietician (RD) who stated that with the tube feeding she made sure the weights were stable, the residents were tolerating the feed, that there was no residual, and that they were tolerating the formula. She further stated that with the tube feedings she monitored those residents monthly instead of quarterly. The surveyor continued to interview the RD who stated that the nurses monitored the residual. She stated that the nurses documented in the progress note how the resident was tolerating the feeding that she reviewed, or the nurses informed her. She further stated that they discussed it during the morning meeting. The RD stated that she did not believe there were physical orders and that it was just a standard of practices for the nurses. The RD stated that the water flushes were an order as she wrote the orders for the formula and the water flushes which were for additional fluids to ensure the residents were meeting their hydration needs which was typical 250 mL every six hours. The RD stated that the nursing generally entered the orders for the flushes before and after medications. She stated that it would 30 mL before and after medications. She explained she just addressed the formula rate, the resident's calorie, and fluid needs. The RD stated that to her knowledge if the residual was over 200 mL, the nurses held the feeding for at least four hours, and if over 300 mL, the feeding would be stopped and the physician would be notified. The RD concluded there was no formal order as for the checking the residual. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/28/23 at 10:25 AM, the surveyor interviewed LPN #2 who stated the process for the FT included checking the placement, checking the residual, but she was unsure of the amount for residual. She further stated that the nurses flushed the FT with 30 mL before and after medication administration and five (5) mL between each medication. She stated that it was rare that they had residents with FT. She further stated they were educated on when Resident #778 arrived to ensure everyone remembered the appropriate steps. The surveyor asked did they need a physician's order to ensure accountability, and LPN #2 replied they needed an order to document for checking the placement, the residual, and the water flushes. LPN #2 stated that it was important to have physician's orders because sometimes things could be overlooked if there is no order and you can forget because being on the floor can be crazy and having the order is necessary as it shows accountability of what we did. She stated she had Resident # 778 three times, and she documented in the Medication Administration Record (MAR) and the Treatment Administration Record (TAR) for checking of the placement and the water flushes, but was unsure of the residual. She stated that with her experience any residual over 200 mL, she would inform the physician. She further stated that if she was unsure of the residual amount and the steps, she would just ask questions, but that was just her. On 6/28/23 at 11:09 AM, the surveyor asked the DON about the monitoring of the residual that was listed on the resident's care plan. The DON in the presence of the survey team stated that anything over 30 mL, she would hold the feeding and call the physician. She then stated that was a low amount [30 mL], and she would have to review to confirm. The surveyor asked if there was no order on when to hold the feeding, and multiple staff members gave different answers, how would you know when to hold the feeding and notify the physician? The DON stated that she did not have an answer. The DON acknowledged that there was no way to ensure accountability if there was no PO. On 6/30/23 at 9:36 AM, the LNHA in the presence of the DON, and the survey team stated that there should be an order for when to hold and notify the physician on a certain amount of residual. The LNHA acknowledged there should be orders for accountability. On 6/30/23 at 10:32 AM, the LNHA provided a copy of the Adult Gastric Residual Monitoring which she stated it was what the RD provided to staff when they had residents on a tube feeding. She stated that she did not believe this was listed in their policy for guidance. A review of the facility provided Adult Gastric Residual Monitoring form undated included, measure gastric residual volumes (GRV) use at least a 60 mL syringe. For continuous pump feedings check every six (6) hours. If GRV< [less than] 200 mL re-instill gastric residual contents and continue with feeding. If the GRV was > (greater than) 200 mL, re-instill gastric residual contents and hold the feedings for one (1) hour than recheck. If residual > (greater than) 300 after rechecking hold the feeding and contact the medical doctor. A review of the facility provided in-service Tube Feeding Update from 5/22/23 to 5/29/23, included review of the enteral feeding connector and basic feeding tube procedures. In addition, it reflected per the [company's name redacted] Nursing Procedures Manual to verify tube placement, aspirate (to draw) contents from the tube with an enteral syringe, flush the enteral tube with 30 mL of water before and after feedings if ordered, assess every four hours for gastrointestinal intolerance by assessing abdominal distention, monitoring for complaints of abdominal pain, do not monitor gastric residual volume routinely. A further review did not include water flushes before and after medications. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's Policy Enteral Nutrition dated reviewed 8/08/22, included .3. The dietician will input from the provider and nurse d. calculates fluid to be provided (beyond the free fluids in formula .11. The nurse confirms that orders for enteral nutrition are complete. Complete orders include f. instructions for flushing (solution, volume, frequency, timing and 24-hour volume). 12. The provider will consider the need for supplement orders, including: a. confirmation of tube placement and g. checks for gastric residual volume (GRV). It further revealed for procedure, to refer to the [company's name redacted] Nursing Procedure Book . A review of the Medication Orders - Receiving and Recording policy date reviewed 1/10/23, included .4. Enteral Orders - when recording orders for tube feedings, specify the type of feeding, amount, frequency of feeding and rationale if prn [as needed]. The order should always specify the amount of flush following the feeding . NJAC:8:39-11.2(b); 27.1(a); 29.2(d)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 43307 Based on observations, interviews, and review of facility documentation, it was determined that the facility failed to a.) ensure respiratory equipment was kept in a clean and sanitary condition to prevent infection and ensure a portable oxygen tank was stored in accordance with facility policy and b.) develop an individualized care plan for the administration and treatment of oxygen. This deficient practice was identified for 1 of 1 residents reviewed for respiratory equipment (Resident #66), and the evidence was as follows: According to the facility's Admission Record face sheet (an admission summary), Resident #66 was admitted to the facility with diagnoses that included but were not limited to heart failure (ineffective heart pumping resulting in fluid build-up in lungs), ischemic cardiomyopathy (weakened heart muscles due to heart disease), and asthma. A review of a the most recent quarterly Minimum Data Set (MDS), an assessment tool, dated 5/29/23, revealed the resident had a brief interview for mental status (BIMS) score of 13 out of 15, which indicated that the resident's cognition was intact. A further review revealed the resident received oxygen. A review of the resident's Order Summary Report revealed an order dated 11/20/22 for continuous oxygen (O2) at three liters per minute (3 lpm) via nasal cannula (NC, the part of the tubing that rests in the nose); check pulse oximeter (POX, measures oxygen saturation in the blood) every shift. A review of Resident #66's corresponding June 2023 Treatment Administration Record (TAR) included the above physician's order and was documented as administered. A review of Resident #66's individualized comprehensive care plan (ICCP) did not include oxygen care and usage. On 6/21/23 at 9:50 AM, during the initial tour of the New Hope Unit, the surveyor observed a portable oxygen tank in a black bag hanging from the wheelchair in Resident #66's room. The undated oxygen tubing was observed connected to the tank and the NC was observed resting on the floor. On 6/22/23 at 9:19 AM, in Resident #66's room, the surveyor observed a portable oxygen tank in a black bag resting on the floor in front of the wheelchair. The undated oxygen tubing was connected to the tank and the NC was resting on the floor. On 6/26/23 at 11:15 AM, in Resident #66's room, the surveyor observed a portable oxygen tank in a black bag resting on the floor in front of the wheelchair. The undated oxygen tubing was connected to the tank and was rolled up and hung on top of the tank. The resident acknowledged that it was the tank that he/she used when they left the facility for their appointment on 6/23/23 and stated, The bag slips over the handle of the wheelchair. (continued on next page)

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	315166	A. Building B. Wing	06/30/2023

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. On 6/26/23 at 11:40 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) caring for Resident #66 who stated that the resident was ordered oxygen to be worn at all times, and that when he/she left the building that they wore oxygen from the portable tank that hung in a black bag off the back of the wheelchair. Together, the surveyor and the LPN observed a portable oxygen tank on the floor in the resident's room and the LPN acknowledged that it was the tank that the resident had left the facility with on 6/23/23. The LPN stated the tank should not have been resting on the floor, and that she was unsure how old the NC tubing was because it was not dated. The LPN stated it was important to keep the equipment off the floor to keep it as clean as possible because it could have gotten dust, dirt, or germs on it. She then removed the tank and tubing from the room. On 6/26/23 at 12:26 PM, the surveyor interviewed the Neighborhood Manager (NM) who stated that NC tubing was dated and changed weekly and that portable oxygen tanks were stored in an oxygen closet in a stand. The surveyor informed the NM of Resident #66's portable oxygen tank observations. The NM acknowledged that the portable oxygen tank should not have been stored on the ground in a resident's room and that it was important for infection control to keep the NC tubing off the ground. On 6/26/23 at 12:40 PM, the surveyor interviewed the Director of Nursing (DON) who stated that portable oxygen tanks were kept in a storage closet on each unit and that once a tank was used, that it would be replaced to the closet. The surveyor informed the DON of Resident #66's portable oxygen tank observations. The DON acknowledged that there should not have been an unused portable oxygen tank left in a resident's room. The DON stated that for safety purposes, the oxygen tank should have been secured and that for infection control, the NC tubing should have been dated and should not have been resting on the floor. 2. On 6/27/23 at 12:12 PM, the surveyor interviewed the Registered Nurse (RN) caring for Resident #66. The RN stated that an ICCP was put together for each resident with their diagnosis, plans for care, assessments and evaluations and that the nurse was able to add or update the ICCP at any time. The RN acknowledged that she would expect to see oxygen on an ICCP, and that it was important to include on the ICCP how many liters of oxygen were ordered and any oxygen treatments for the resident in case of shortness of breath. In the surveyor's presence, the RN reviewed Resident #66's ICCP and stated she did not see oxygen listed. On 6/27/23 at 12:20 PM, the surveyor interviewed the NM who stated that an ICCP was a resource used to provide the desired care and a picture of the resident's needs. He stated that it was created and updated by the interdisciplinary team and that every discipline was able to update it. The NM stated that he would have expected to see a respiratory ICCP that mentioned oxygen therapy or an actual order that the resident was on oxygen. The NM acknowledged that Resident #66 wore oxygen continuously. In the surveyor's presence, the NM reviewed Resident #66's ICCP and stated he did not see oxygen listed, and that oxygen should have been on the ICCP. He further stated that it was important to include oxygen on the ICCP so that everyone could have made sure the resident was provided appropriate care. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/27/23 at 12:26 PM, the surveyor interviewed the DON who stated that an ICCP listed the care that the resident required and that the nurse should have been familiar with each resident's ICCP and should have reviewed the ICCP for any updates. The DON stated that if a resident was on oxygen, that she would have expected to see oxygen on the ICCP. In the surveyor's presence, the DON reviewed Resident #66's ICCP and acknowledged she it did not include oxygen, and that oxygen should have been included. She further stated that it was important for oxygen to be on the ICCP so that everyone would have known what the plan was for the resident's oxygen usage. On 6/28/23 at 11:09 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) who stated that oxygen tanks were stored in the oxygen closets and that if a resident needed portable oxygen, that the nurse retrieved a portable tank from the closet and placed it in a sling bag on the resident's wheelchair, or may use the rollator (metal bracket on wheels that holds the portable oxygen tank). The LNHA stated the portable oxygen tanks should not have been stored in resident's rooms, the tanks should have always been in a holder off the floor and the NC tubing should not have been resting on the floor. The surveyor informed the LNHA of Resident #66's portable oxygen tank observations. The LNHA acknowledged that the portable oxygen tank should not have been stored on the floor in the resident's room and that it should have been in the oxygen closet, and that the NC tubing should have been dated and secured in a plastic bag. During the same interview, the LNHA stated that an ICCP was a plan of care provided to each resident while at the facility. She stated that the ICCP was completed by the interdisciplinary care team, that everyone contributed based on the needs of the resident, and that it was used by all clinical team members. The LNHA stated that if a resident was ordered continuous oxygen, that she would have expected to see oxygen on the ICCP. She further stated that it was important for oxygen to be included on the ICCP so that the team was made aware that the resident was on oxygen, any breathing issues would have been monitored, it would have been used to confirm the correct amount of oxygen was being administered, and that if the resident were to go out to an appointment that they would have been aware that the resident would have needed continuous oxygen. A review of facility's Oxygen, policy dated revised 8/6/22, included A. Storage, Oxygen is to be kept in designated areas on the nursing units except when in use . 2. Portable O2 (oxygen) tanks will be available and secured in a rack .C. Safety .2. Oxygen must be kept in a stand or cart . D. Method of Delivery, O2 will be administered via nasal cannula unless otherwise specified by physician order. Nasal cannula to be changed weekly and PRN (as needed) . A review of facility's Care Planning, policy dated revised 8/1/21, included .I. Procedure .B. The comprehensive care plan is based on a thorough assessment that includes, but is not limited to, the MDS. C. Each resident's comprehensive care plan is designed to: a. Incorporate identified problem areas; b. Incorporate risk factors associated with identified problems .e. Reflect treatment goals, timetables and objectives in measurable outcomes .g. Aid in preventing or reducing declines in the resident's functional status and/or functional levels . E .the care plan outlines those individualized interventions to specifically address the resident's issues . NJAC 8:39-11.2(e), 27.1(a)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 37218 Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to appropriately label and date two Tubersol (tuberculin purified protein derivative [PPD]; a clear, colorless solution injected into the skin of the forearm that aides in the detection of tuberculosis). This deficient practice was identified in 1 of 2 medication storage rooms inspected in the facility (Magnolia nursing unit), and was evidenced by the following: On 6/21/23 at 11:30 AM, the surveyor inspected the medication storage room by the Magnolia nursing unit in the presence of the Registered Nurse (RN). At that time, the surveyor observed two opened and undated Tubersol solutions in the refrigerator. On 6/21/23 at 11:34 AM, the surveyor interviewed the RN who stated that the Tubersol was to be dated when it was opened. The RN then told the surveyor that she was not sure if the Tubersol was supposed to be dated upon opening, and wanted to ask another staff member. The RN then exited the medication storage room. On 6/21/23 at 11:36 AM, the RN re-entered the medication storage room and informed the surveyor that her Unit Manager/Registered Nurse (UM/RN) told her the medication was supposed to be dated upon opening. On 6/21/23 at 11:39 AM, the surveyor interviewed the UM/RN who confirmed the Tubersol should have been dated upon opening and stored in the refrigerator. The UM/RN further stated that it was important to date the medication, for expiration purposes. On 6/23/23 at 11:43 AM, the surveyor conducted an interview over the telephone with the facility's Consultant Pharmacist (CP) who stated that upon opening the medication Tubsersol, the medication was required to be dated. The CP explained after the medication was opened, it was only good for usage for 28 - 30 days per the manufacturer' specifications for usage. On 6/23/23 at 12:36 PM, the surveyor interviewed the Director of Nursing (DON) who stated that the Tubsersol needed to be dated upon opening because the medication was only good for 30 days. The DON acknowledged it was important to date the medication, so the nursing staff knew when the medication was going to expire. A review of the undated Tubsersol package insert from the Food and Drug Administration included .A vial of Tubersol which has been entered and in use for 30 days should be discarded . A review of facility's pharmacy, Medication Storage Guidelines dated 2022, included Tubersol was required to be dated upon opening and the unused portion was to be discarded after 30 days . A review of the facility's, Medication Storage Policy dated 10/6/22, included .medications were labeled accordingly . (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	NJAC 8:39-29.6(b)1