

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  10/15/2024
NAME OF PROVIDER OR SUPPLIER  Masonic Village at Burlington		STREET ADDRESS, CITY, STATE, ZIP CODE  902 Jacksonville Road Burlington, NJ 08016	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0656</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50267</b></p> <p>Based on observation, interviews and record review, as well as review of pertinent facility documents on 10/08/24 and 10/10/24, it was determined that the facility failed to implement a care plan dated 8/06/2024 that identified a nutritional risk. The care plan revised on 8/6/24 listed a ground texture diet with thin liquids as an intervention. On 9/29/24, Resident #2, with a diagnosis of Dysphagia (difficulty swallowing) and Cerebral Infarction (Stroke), had a Physician's Diet order for Mechanical Soft Ground texture, was served a regular consistency hot dog on a bun by the assigned Certified Nursing Assistant (CNA #2). After serving Resident #2 their lunch tray, CNA #2 left and went to assist another resident. On her way out of assisting the other resident, CNA #2 observed Resident #2's call light on. CNA #2 responded to Resident #2's call light and observed the resident was blue and choking. The CNA #2 called the nursing staff who intervened by performing the Heimlich maneuver (abdominal thrust) which dislodged the hot dog from Resident #2's throat.</p> <p>This deficient practice created an Immediate Jeopardy (IJ) situation to the health and well-being of Resident #2 and the potential to affect all residents on a therapeutic diet at risk for serious injury or death if not served with the correct diet consistency. The IJ was identified on 10/10/24 at 8:13 p.m. and the IJ template was presented to the Licensed Nursing Home Administrator (LNHA) in the presence of the Director of Nursing (DON). The IJ began on 9/29/24 and continued through 10/11/24 when an acceptable removal plan was implemented and continues to run at a D level for no actual harm.</p> <p>A care plan initiated on 8/2/24 identified a problem of history of cerebral vascular accident (stroke) and dysphagia was updated on 10/8/24. An update was to supervise the resident during meals. On 10/10/24, the surveyor entered the resident's room with the assigned nurse (RN #1), and observed resident with the meal in front of him/her unsupervised and meal was partially eaten.</p> <p>The facility provided an acceptable Removal Plan on 10/11/24. On 10/15/24, the surveyor conducted a Removal Plan visit and verified that the Removal Plan was implemented.</p> <p>On 10/11/24, the facility implemented the Removal Plan, which included the following:</p> <p>The Director of Nursing conducted an audit to ensure all dietary orders, recommendations, and documentation were accurate in the medical record and matched the dietary department's tray card information for each resident. Thirty six residents were identified that required assistance with meals.</p> <p>On 10/11/24, the Facility policies and procedures Therapeutic Diets were reviewed/revised.</p> <p>(continued on next page)</p>

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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<p>F 0656</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 10/11/24, education was provided to the staff by the Staff Educator or designee regarding applicable facility policies and procedures titled Therapeutic Diets, diet consistency, compliance with resident-specific dietary interventions, supervision and food preparation consistent with each resident's dietary order including when a mandatory snack or alternative meal is provided. Mandatory in service was held on 10/11/24. All staff who could not attend was not be permitted to work until they completed the mandatory in service. The mandatory in service was added to the new hire orientation and for all future nursing and dietary personnel.</p> <p>On 10/11/24, a member of the Interdisciplinary Team (IDT) team and or nurse was assigned to each floor to monitor staff compliance with supervision at mealtimes. A minimum of two managers were assigned at lunch time.</p> <p>On 10/11/24, the Director of Nursing or Designee audited all new admissions to ensure the dietary orders/recommendations/documentation were accurate in the medical record and matched the dietary department's tray card information for that resident.</p> <p>On 10/11/24, The Dietary Manager or designee monitored food preparation at all three meals and compared the meal and or snacks being prepared to the physician order/documentation for each resident's dietary needs.</p> <p>On 10/11/24, residents requiring assistance and or supervision with meals were encouraged to eat in the bistro, and residents who preferred to eat in their room were noted on the resident Kardex. A staff member was assigned to assist these residents during mealtime in the bistro and or resident rooms.</p> <p>On 10/11/24, a member of the IDT team and or nurse was assigned to each floor to monitor staff compliance with supervision at mealtimes.</p> <p>On 10/11/24, the Administrator implemented a Quality Assurance and Performance Improvement (QAPI) Performance Improvement Projects (PIP) in order to gather and process information from the audits/monitoring processes and findings to be reported at the monthly Quality Assessment and Assurance (QAA) meeting for a minimum of three months.</p> <p>This deficient practice was evidenced by the following:</p> <p>According to the Admission Record (AR), Resident #2 was admitted to the facility on [DATE], with diagnoses that included but were not limited to Cerebral Infarction (stroke), and Dysphagia (difficulty swallowing).</p> <p>Review of the Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 8/8/24, revealed that Resident #2 had a Brief Interview for Mental Status (BIMS) score of 9/15, which indicated that the Resident's cognition was moderately impaired. The MDS also indicated that the Resident was on a mechanically altered diet and required Partial/moderate assistance with eating.</p> <p>Review of Resident #2's Care Plan (CP) initiated on 8/2/24, identified the followings as problems: History of (H/O) CVA left sided weakness,</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Diagnosis (DX) of Dysphagia - set up meals, needs cueing (refers to a signal or a stimulus that results in an action).</p> <p>Under Interventions, section of the CP, revealed the following interventions including but not limited to: Encourage rest periods as needed, Diet as ordered: regular, ground texture .</p> <p>Resident #2 CP initiated on 8/02/2024 with a problem of history of cerebral vascular accident was revised post incident on 10/08/2024. The revision included the following interventions including but not limited to: Ensure resident is sitting upright during meals, monitor resident for any coughing during meals, and supervise the resident during meals.</p> <p>Review of the Order Summary Report (OSR) dated 10/8/24, showed an active order for Mechanical Soft Ground texture for Resident #2.</p> <p>Review of Resident #2's Progress Notes (PN), dated 9/29/23 at 14:00, revealed that Resident #2 had a choking episode. Resident placed call light on, when aide entered room, resident was blue and choking on her lunch. The aide called for help, all nurses helped perform upward compressions to chest to dislodge food, supervisor was notified and helped as well. One of the student nurses performed the Heimlich, helping relieve what was stuck in her throat. Further review of progress notes at 14:09 revealed that chest x-ray (CXR) was ordered to rule out (r/o) aspiration and rib fracture (fx) status post (s/p) chest compressions due to choking on food.</p> <p>Review of the Facility Reportable Event (FRE) submitted to the New Jersey Department of Health (NJDOH) for resident [Resident #2], dated 9/29/24, indicated that on 9/29/24 Resident #2 was given a meal tray that consisted of hotdog on a bun by the assigned CNA [CNA #2]. A short time after tray was delivered to Resident #2, she was observed Resident #2 choking. CNA #2 made nursing staff aware that Resident #2 was choking and responded immediately. The nurses performed the Heimlich Maneuver (abdominal thrust), suctioning, and applied oxygen. The nursing staff successfully dislodged the hot dog from Resident #2's throat. Provider was made aware, and a chest x-ray was ordered.</p> <p>Review of the FRE statement dated 9/29/24 from the Bistro staff (DS #3) indicated that the CNA (CNA #2) asked for a hot dog, and he gave it to her. DS #3 further stated that CNA #2 did not ask him to chop up the hotdog, and she did not ask or told him who it was for.</p> <p>Review of the FRE statement dated 9/29/24 from the assigned CNA (CNA #2) revealed that CNA #2 chopped up the hotdog that she received from the Bistro staff and gave it to Resident #2 who was on a mechanical soft ground diet. CNA #2 stated that she then left Resident #2 to assist another resident, was alerted by Resident #2's call bell, and found Resident #2 blue and was choking on hot dog that she gave to Resident #2.</p> <p>In an interview with Resident #2 on 10/8/24 at 12:46 p.m., Resident #2 stated, I could not breathe, I felt like I was going to pass out. Now I look the food over before I eat it and make sure it is not too big. Now I am apprehensive each time I have to eat, because I am worried it's going to be too big of pieces that I can't swallow.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In an interview with Resident #2's assigned CNA (CNA #2) on 10/18/24 at 3:04 p.m., revealed that if a resident asked for an item on the alternative menu, it should be verified with the nurse or dietician. CNA #2 confirmed that she did not verify with the dietician because it was a weekend and the dietician was not at facility, and she also did not verify with the nurse. CNA #2 stated that she was aware of Resident #2's diet, saw pictures in the nursing documentation room, was in-serviced on the various types of diet, had access to verify resident's diet on the Point of Care (POC) system, and was aware of what a mechanical soft ground consistency diet looked like. CNA #2 admitted that she received a regular hot dog from the Bistro staff (DS #3), she chopped up the hot dog. CNA #2 confirmed that it was not the consistency the doctor ordered when she gave it to Resident #2. CNA #2 stated that Resident #2 should not have been given chopped hot dog because Resident #2 was unable to chew it properly, and it was a choking hazard.</p> <p>In an interview with the Bistro staff (DS #3) on 10 /21/24 at 11:45 a.m., he stated that he received the hot dog from the kitchen in a plastic container labeled with Resident #2's information on it. DS #3 stated that he saw that the resident was on a regular diet but did not saw that resident was on a mechanical soft ground textured diet.</p> <p>According to an Incident Investigation form dated 9/29/2024, the facility indicated that residents who were on mechanically altered diets were to be encouraged to eat in the Bistro area. If a resident with mechanically altered diet refused to eat in the Bistro, this must be reflected in the care plan. Those residents and if they declined and ate in their room, they would be supervised during their meal.</p> <p>On 10/10/24 at 10:33 a.m., the surveyor entered the Resident #2's room with the assigned Registered Nurse (RN), and Resident #2 was observed with his/her meal in front of him/her unsupervised. The resident stated that he/she had eaten some of the meal.</p> <p>In an interview with the assigned nurse for Resident #2 (RN #1) on 10/10/24 at 10:58 a.m., RN #1 confirmed with surveyor that she had not received any in-service since Resident #2's choking incident on 9/29/24.</p> <p>In an interview with the Administrator on 10/10/24 at 11:44 a.m., the Administrator confirmed that Resident #2 should not have been in his/her room with tray table with breakfast in front of him/her unsupervised. Administrator also stated that Resident #2 had a choking event and should not have had a breakfast plate in front of him/her unattended.</p> <p>A review of the 'Orientation Checklist' for CNA #2 dated 7/17/24, indicated that CNA #2 met the understanding of Resident Nutrition including food consistency.</p> <p>A review of an undated policy named, Food and Nutrition Services showed, Food and nutrition services staff will inspect food trays to ensure that the correct meal is provided to each resident, and If an incorrect meal is provided to a resident ., nursing staff will report it to the food service manager so that a new food tray can be issued.</p> <p>A review of an undated policy called Ordering off of the Alternate Menu, showed that if a resident ordered an item off the always available menu, their food is then checked against their diet order, texture order, and all allergies.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50267</b></p> <p>Based on observation, interviews and record review, as well as review of pertinent facility documents on 10/08/24 and 10/10/24, it was determined that the facility failed to provide a mechanically altered diet as the physician prescribed for 1 of 4 sampled resident (Resident #2), on 9/29/24, who had a Physician's Diet order for Mechanical Soft Ground texture. Resident #2, with a diagnosis of Dysphagia (difficulty swallowing) and Cerebral Infarction (Stroke), was served a regular consistency hot dog on a bun by the assigned Certified Nursing Assistant (CNA #2). After serving Resident #2 their lunch tray, CNA #2 left and went to assist another resident. On her way out of assisting the other resident, CNA #2 observed Resident #2's call light on. CNA #2 responded to Resident #2's call light and observed the resident was blue and choking. The CNA #2 called the nursing staff who intervened by performing the Heimlich maneuver (abdominal thrust) which dislodged the hot dog from Resident #2's throat.</p> <p>This deficient practice created an Immediate Jeopardy (IJ) situation to the health and well-being of Resident #2 and the potential to affect all residents on a therapeutic diet at risk for serious injury or death if not served with the correct diet consistency. The IJ was identified on 10/10/24 at 8:13 p.m. and the IJ template was presented to the Licensed Nursing Home Administrator (LNHA) in the presence of the Director of Nursing (DON). The IJ began on 9/29/24 and continued through 10/11/24 when an acceptable removal plan was implemented and continues to run at a D level for no actual harm.</p> <p>A care plan initiated on 8/2/24 identified a problem of history of cerebral vascular accident (stroke) and dysphagia was updated on 10/8/24. An update was to supervise the resident during meals. On 10/10/24, the surveyor entered the resident's room with the assigned nurse (RN #1), and observed resident with the meal in front of him/her unsupervised and meal was partially eaten.</p> <p>The facility provided an acceptable Removal Plan on 10/11/24. On 10/15/24, the surveyor conducted a Removal Plan visit and verified that the Removal Plan was implemented.</p> <p>On 10/11/24, the facility implemented the Removal Plan, which included the following:</p> <p>The Director of Nursing conducted an audit to ensure all dietary orders, recommendations, and documentation were accurate in the medical record and matched the dietary department's tray card information for each resident. Thirty six residents were identified that required assistance with meals.</p> <p>On 10/11/24, the Facility policies and procedures Therapeutic Diets were reviewed/revised.</p> <p>On 10/11/24, education was provided to the staff by the Staff Educator or designee regarding applicable facility policies and procedures titled Therapeutic Diets, diet consistency, compliance with resident-specific dietary interventions, supervision and food preparation consistent with each resident's dietary order including when a mandatory snack or alternative meal is provided. Mandatory in service was held on 10/11/24. All staff who could not attend was not be permitted to work until they completed the mandatory in service. The mandatory in service was added to the new hire orientation and for all future nursing and dietary personnel.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 10/11/24, a member of the Interdisciplinary Team (IDT) team and or nurse was assigned to each floor to monitor staff compliance with supervision at mealtimes. A minimum of two managers were assigned at lunch time.</p> <p>On 10/11/24, the Director of Nursing or Designee audited all new admissions to ensure the dietary orders/recommendations/documentation were accurate in the medical record and matched the dietary department's tray card information for that resident.</p> <p>On 10/11/24, The Dietary Manager or designee monitored food preparation at all three meals and compared the meal and or snacks being prepared to the physician order/documentation for each resident's dietary needs.</p> <p>On 10/11/24, residents requiring assistance and or supervision with meals were encouraged to eat in the bistro, and residents who preferred to eat in their room were noted on the resident Kardex. A staff member was assigned to assist these residents during mealtime in the bistro and or resident rooms.</p> <p>On 10/11/24, a member of the IDT team and or nurse was assigned to each floor to monitor staff compliance with supervision at mealtimes.</p> <p>On 10/11/24, the Administrator implemented a Quality Assurance and Performance Improvement (QAPI) Performance Improvement Projects (PIP) in order to gather and process information from the audits/monitoring processes and findings to be reported at the monthly Quality Assessment and Assurance (QAA) meeting for a minimum of three months.</p> <p>On 9/29/24, Certified Nursing Assistant (CNA) gave Resident #2 a regular consistency hot dog on a bun, who had a history of Dysphagia (difficulty swallowing) and Cerebral Infarction (stroke), and a physician's order for Mechanical Soft Ground textured diet. This caused the resident to choke, putting the resident at risk for serious harm or death which resulted in an immediate jeopardy (IJ). The Administrator and Director of Nursing (DON) were notified of the IJ on 10/10/24 at 8:15 p.m. and was provided the IJ template. The IJ began on 9/29/24 and continued thru 10/11/24.</p> <p>This deficient practice was evidenced by the following:</p> <p>According to the Admission Record (AR), Resident #2 was admitted to the facility on [DATE], with diagnoses that included but were not limited to: Cerebral Infarction (stroke), and Dysphagia (difficulty swallowing).</p> <p>According to the Minimum Data Set (MDS), an assessment tool dated 8/8/24, Resident #2 had a Brief Interview for Mental Status (BIMS) score of 9/15, which indicated that the Resident's cognition was moderately impaired. The MDS also indicated that the Resident was on a mechanically altered diet and required Partial/moderate assistance with eating.</p> <p>Review of the Care Plan (CP) initiated on 8/2/24, revealed under problem documented, Resident #2 has diagnosis (DX) Dysphagia - set up meals, needs cueing (refers to a signal or a stimulus that results in an action). Further review of the CP included an intervention of Diet as ordered: regular, ground texture .</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of the Order Summary Report (OSR) dated 10/8/24, revealed an active order for Mechanical Soft Ground texture for Resident #2.</p> <p>Review of Resident #2's Progress Notes (PN) dated 9/29/23 at 14:00 confirmed that Resident #2 had a choking episode. Further review of the PN, dated 9/29/24 at 14:00 revealed that the resident was blue and choking on his/her lunch. The aide called for help, all nurses helped performed upward compressions to chest to dislodge food, supervisor made aware and helped. A nursing student performed the Heimlich, helping to relieve what was stuck in his/her throat. Nursing narrative PN by nursing supervisor at 14:09 (2:09 p.m.) noted that chest x-ray (CXR) was ordered to rule out (r/o) aspiration and rib fractures status post (s/p) chest compressions due to choking on food.</p> <p>Review of the Facility Reportable Event (FRE) submitted to NJDOH (New Jersey Department of Health) for Resident #2, dated 9/29/24, indicated that on 9/29/24, CNA gave Resident #2 a hotdog on a bun that was inconsistent with resident's diet, which caused Resident #2 to choke, and airway was blocked. The nurses provided Heimlich Maneuver, suctioned Resident #2, and oxygen was initiated. The nursing staff was able to successfully remove the contents. Provider was made aware, and a chest x-ray was ordered.</p> <p>Review of statement from the FRE dated 9/29/24 from the Bistro staff (DS #3) indicated that the CNA asked for a hot dog, and he gave it to her. CNA did not ask him to chop it up, and she did not ask or told him who it was for.</p> <p>Review of a statement from the FRE dated 9/29/24 given by the assigned CNA (CNA #2) revealed that CNA chopped the hotdog that she received from the Bistro staff and gave to Resident #2 who was on a mechanical soft ground diet, then left Resident #2 to assist another resident. CNA was alerted by Resident #2's call bell and found Resident #2 blue and was choking on hot dog that he/she gave to Resident #2.</p> <p>In an interview with CNA #2 on 10/18/24 at 3:04 p.m., CNA stated that if a resident asked for an item on the alternative menu, he/she was to verify with the nurse or dietician. CNA #2 confirmed that he/she did not verify with the dietician because it was a weekend and the dietician was not at the facility, and that he/she also did not verify with the nurse. CNA #2 further stated that he/she was aware of Resident #2's diet, saw pictures in the nursing documentation room, was in-serviced on types of diet, had access to verify on Point of Care (POC), and was aware of what a mechanical soft ground consistency diet looked like. CNA #2 admitted that the consistency of the hot dog given to Resident #2 was not the consistency the doctor ordered, and further stated that Resident #2 should not have been given the chopped hot dog because he/she was unable to chew it properly, and it was a choking hazard.</p> <p>In an interview with the Bistro staff (DS #3) on 10/21/24 at 11:45 a.m., DS #3 stated he received the hot dog in a plastic container labeled with Resident #2's information on it. DS #3 stated that he saw that the resident was on a regular diet but did not see that resident was on a mechanical soft ground textured diet. DS #3 further stated that he was the only staff working in the Bistro on 9/29/24. DS #3 stated that the Bistro staff does not alter any items that was sent up from the kitchen.</p> <p>According to an Incident Investigation form dated 9/29/2024 the facility indicated that residents who were on mechanically altered diets were to be encouraged to eat in the Bistro and if they declined and ate in their room, they would be supervised during their meal.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In an interview with Resident #2 on 10/8/24 at 12:46 p.m., Resident #2 stated, I could not breathe, I felt like I was going to pass out. Now I look the food over before I eat it and make sure it is not too big. Now I am apprehensive each time I have to eat, because I am worried it's going to be too big of pieces that I can't swallow.</p> <p>On 10/10/24 at 10:33 a.m., surveyor observed along with Resident #2's assigned nurse (RN #1), Resident #2 in his/her room in bed with bedside table across bed in front of Resident #2 with a plate of scrambled egg (mashed) and ground sausage link (ground), and Resident #2 was unsupervised.</p> <p>In an interview with RN #1 on 10/10/24 at 10:58 a.m., RN #1 stated that she had not received in-service since Resident #2's choking incident on 9/29/24.</p> <p>In an interview with the Administrator on 10/10/24 at 12:24 p.m., the administrator stated that the Bistro staff and CNA should have confirmed which resident the meal was for, and that the Bistro staff should have verified which resident was getting the hot dog, so the resident got the appropriate diet to prevent choking. Further interview with the administrator at 1:13 p.m. confirmed that residents who were on an altered diet who did not go to the Bistro must be supervised. Administrator stated that Resident #2 should not have been in his/her room with tray table with breakfast in front of him/her unsupervised. Administrator also stated that Resident #2 had a choking event and should not have had a breakfast plate in front of him/her unattended.</p> <p>In an interview with the Education Manager on 10/10/24 at 11:55 a.m. revealed that the emergency in-service on dietary orders and types was given with focus on nursing staff for 7:00 a.m. - 3:00 p.m. shift and 3:00 p.m. - 11:00 p.m. shift. The Education Manager stated that she has not done an in-service with the 11:00 p.m. - 7:00 a.m. shift. The Education Manager stated that the nursing staff that was not present for the in-service post incident, has not received in-service as of today 10/10/2024. The Education Manager further stated that the possibility existed that an 11 p.m. - 7:00 a.m. staff could work 7:00 a.m. - 3:00 p.m. or 3:00 p.m. to 11:00 p.m.</p> <p>Review of a document titled, 'Orientation Checklist' for CNA #2 dated 7/17/24, showed that CNA #2 met the understanding of Resident Nutrition including food consistency.</p> <p>Review of the LCS Operations Procedures &amp; Quality Standards Manual dated LCS 2015, below Therapeutic Menu Planning, displayed that Mechanical soft: this diet offers food that are easily chewed and often recommended for patients with digestive problems or chewing and swallowing difficulties. In the same manual below Guidelines for Observing Meal Services, in Posted Mealtimes displayed, Therapeutic diets served correctly - check tray card/menu slip versus menu on board next to steam table versus food served, and Mechanically altered diets served correctly.</p> <p>Review of the undated policy named, Food and Nutrition Services revealed: Food and nutrition services staff will inspect food trays to ensure that the correct meal is provided to each resident, and If an incorrect meal is provided to a resident, nursing staff will report it to the food service manager so that a new food tray can be issued.</p> <p>Review of the undated policy named Ordering off of the Alternate Menu, showed that if a resident ordered an item off the always available menu, their food is then checked against their diet order, texture order, and all allergies.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>8:39-17.4(a)(1)</p>

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<p>F 0808</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50267</b></p> <p>Based on observation, interviews and record review, as well as review of pertinent facility documents on 10/08/24 and 10/10/24, it was determined that the facility failed to provide a therapeutic diet for 1 of 4 sampled residents (Resident #2) on 9/29/2024, who had a Physician's Diet order for Mechanical Soft Ground texture. Resident #2, with a diagnosis of Dysphagia (difficulty swallowing) and Cerebral Infarction (Stroke), was served a regular consistency hot dog on a bun by the assigned Certified Nursing Assistant (CNA #2). After serving Resident #2 with lunch tray, CNA #2 left and went to assist another resident. On her way out of assisting the other resident, CNA #2 observed Resident #2's call light on. CNA #2 responded to Resident #2's call light and observed the resident was blue and choking. The CNA #2 called the nursing staff who intervened by performing the Heimlich maneuver (abdominal thrust) which dislodged the hot dog from Resident #2's throat.</p> <p>This deficient practice created an Immediate Jeopardy (IJ) situation to the health and well-being of Resident #2 and the potential to affect all residents on a therapeutic diet at risk for serious injury or death if not served with the correct diet consistency. The IJ was identified on 10/10/24 at 8:13 p.m. and the IJ template was presented to the Licensed Nursing Home Administrator (LNHA) in the presence of the Director of Nursing (DON). The IJ began on 9/29/24 and continued through 10/11/24 when an acceptable removal plan was implemented and continues to run at a D level for no actual harm.</p> <p>A care plan initiated on 8/2/24 identified a problem of history of cerebral vascular accident (stroke) and dysphagia was updated on 10/8/24. An update was to supervise the resident during meals. On 10/10/24, the surveyor entered the resident's room with the assigned nurse (RN #1), and observed resident with the meal in front of him/her unsupervised and meal was partially eaten.</p> <p>The facility provided an acceptable Removal Plan on 10/11/24. On 10/15/24, the surveyor conducted a Removal Plan visit and verified that the Removal Plan was implemented.</p> <p>On 10/11/24, the facility implemented the Removal Plan, which included the following:</p> <p>The Director of Nursing conducted an audit to ensure all dietary orders, recommendations, and documentation were accurate in the medical record and matched the dietary department's tray card information for each resident. Thirty six residents were identified that required assistance with meals.</p> <p>On 10/11/24, the Facility policies and procedures Therapeutic Diets were reviewed/ revised.</p> <p>On 10/11/24, education was provided to the staff by the Staff Educator or designee regarding applicable facility policies and procedures titled Therapeutic Diets, diet consistency, compliance with resident-specific dietary interventions, supervision and food preparation consistent with each resident's dietary order including when a mandatory snack or alternative meal is provided. Mandatory in service was held on 10/11/24. All staff who could not attend was not be permitted to work until they completed the mandatory in service. The mandatory in service was added to the new hire orientation and for all future nursing and dietary personnel.</p> <p>(continued on next page)</p>		

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<p>F 0808</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 10/11/24, a member of the Interdisciplinary Team (IDT) team and or nurse was assigned to each floor to monitor staff compliance with supervision at mealtimes. A minimum of two managers were assigned at lunch time.</p> <p>On 10/11/24, the Director of Nursing or Designee audited all new admissions to ensure the dietary orders/recommendations/documentation were accurate in the medical record and matched the dietary department's tray card information for that resident.</p> <p>On 10/11/24, The Dietary Manager or designee monitored food preparation at all three meals and compared the meal and or snacks being prepared to the physician order/documentation for each resident's dietary needs.</p> <p>On 10/11/24, residents requiring assistance and or supervision with meals were encouraged to eat in the bistro, and residents who preferred to eat in their room were noted on the resident Kardex. A staff member was assigned to assist these residents during mealtime in the bistro and or resident rooms.</p> <p>On 10/11/24, a member of the IDT team and or nurse was assigned to each floor to monitor staff compliance with supervision at mealtimes.</p> <p>On 10/11/24, the Administrator implemented a Quality Assurance and Performance Improvement (QAPI) Performance Improvement Projects (PIP) in order to gather and process information from the audits/monitoring processes and findings to be reported at the monthly Quality Assessment and Assurance (QAA) meeting for a minimum of three months.</p> <p>Review of the Facility Reportable Event (FRE) submitted to the New Jersey Department of Health (NJDOH) for resident [Resident #2], dated 9/29/24, indicated that on 9/29/24, Resident #2 was given a meal tray during lunch service, that consisted of hotdog on a bun by the assigned CNA [CNA #2]. The CNA then left Resident #2, and later saw the call light on, went to Resident #2's room, and saw Resident #2 choking. CNA #2 called nursing staff who intervened by performing the Heimlich Maneuver (abdominal thrust), which dislodged the hot dog from Resident #2's throat.</p> <p>According to the Admission Record Face Sheet, Resident #2 was admitted to the facility on [DATE], with diagnosis that included but were not limited: Cerebral Infarction (stroke) and Dysphagia (difficulty swallowing).</p> <p>The Minimum Data Set (MDS), an assessment tool dated 8/8/24, showed that the Resident had a Brief Interview for Mental Status (BIMS) score of 09/15, which indicated that the Resident had moderate impairment in cognition. The MDS also indicated that the Resident was on a mechanically altered diet and required Partial/moderate assistance with eating.</p> <p>According to Resident #2's Care Plan initiated on 8/02/2024,</p> <p>(continued on next page)</p>

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<p>F 0808</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Resident #2 had a history of Cerebral Vascular Accident (CVA) [Stroke], left sided weakness, and diagnosed with Dysphagia - set up for meals, needs cueing. Interventions included but not limited to Diet as ordered, monitor for signs and symptoms (s/s) aspiration. Care Plan initiated on 08/06/2024 showed Resident #2 is at nutritional risk as evidenced by mechanically altered diet due to but were not limited to Cerebral Infarction and Dysphagia. Interventions included but not limited to Diet as ordered: regular, ground textured with thin liquids.</p> <p>A review of the Physician's Orders on Order Summary Report dated 10/8/24, showed an order for Mechanical ground Soft Ground texture. It further showed, Diet order - Resident receives physician ordered diet every shift. Regular diet, Mechanical Soft Ground texture.</p> <p>Review of Resident #2's Progress Notes (PN), dated 9/29/23 at 14:00, revealed that Resident #2 had a choking episode. Resident placed call light on, when aide entered room, resident was blue and choking on her lunch. The aide called for help, all nurses helped perform upward compressions to chest to dislodge food, supervisor was notified and helped as well. One of the student nurses performed the Heimlich, helping relieve what was stuck in her throat. Further review of progress notes at 14:09 revealed that chest x-ray (CXR) was ordered to rule out (r/o) aspiration and rib fracture (fx) status post (s/p) chest compressions due to choking on food.</p> <p>During an interview with the Registered Dietician/Clinical Nutrition Manager on 10/8/24 at 10:14 a.m., she confirmed that Resident #2's was ordered ground diet and that a mechanical soft ground diet should have been delivered to resident.</p> <p>During an interview with Resident #2 on 10/8/24 at 12:46 p.m., Resident #2 stated, I could not breathe, I felt like I was going to pass out. Now I look the food over before I eat it and make sure it is not too big. Now I am apprehensive each time I have to eat, because I am worried it's going to be too big of pieces that I can't swallow.</p> <p>During an interview with the Speech Therapist on 10/8/24 at 1:42 p.m., she stated that Resident #2 had a Fiberoptic Endoscopic Evaluation Swallow (FEES) [procedure used to assess how well you swallow] test was done at facility while in subacute and maintained same diet when transferred to Long Term Care (LTC), mechanical soft ground. Speech Therapist stated that speech therapy became involved about 4 weeks ago when Resident #2 requested to eat a higher texture which included cereal and blueberry. Speech Therapist stated Resident #2 was evaluated and it was determined that it was not safe for Resident #2's diet to be upgraded. Speech Therapist further stated that there was an always available menu and that the items are not readily available in modified textures. She also stated that the CNA should have also checked to make sure the resident received the appropriate diet.</p> <p>During an interview with the Administrator on 10/8/24 at 3:30 p.m., he confirmed that the hot dog was whole and that it was not the consistency per doctor order.</p> <p>During an interview with the Executive Director of Dining Services (DS#6) on 10/10/24 at 9:31 a.m., he stated, Residents are offered what is on the menu. For alternative/everyday menu, resident may request from nursing staff any item off the alternate menu. The nursing staff should go to the Bistro staff and ask them to call the kitchen to order item. If an order is requested for mechanical soft ground, it would be prepared as ordered. DS#5 further stated that Resident #2 should not have received a whole hot dog as it is a choking hazard, could choke, and was on a therapeutic diet.</p> <p>(continued on next page)</p>		

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<p>F 0808</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview with Resident Experience Manager - Dining Services (DS # 5) on 10/10/24 at 9:48 a.m., he stated that Resident #2 should not have received a whole hot dog because he/she could choke.</p> <p>During observation of a whole hot dog processed into mechanical soft ground texture, on 10/10/24 at 9:59 a. m., the Lead [NAME] - Dining Services (DS #4) placed hot dog in a steamer for 5 minutes, temperature checked for doneness, temperature was 178.5 degrees, then placed in robot coupe, pulse mode used for proper consistency, then transferred to 8 size pan to be transported to the Bistro.</p> <p>During the meal observation in the presence of Resident #2's assigned nurse (RN #1) on 10/10/24 at 10:33 a. m., the surveyor observed that Resident #2 was served a breakfast tray which consisted of scrambled egg (mashed) and ground sausage link (ground), and no staff was in the room with resident during meal.</p> <p>During interview with LEA Dining Services (DS #2) on 10/10/24 at 10:45 a.m., she stated, If a CNA asked for a regular hot dog, which is not on a regular menu, I call the kitchen and request the hot dog. I need to know the name of the resident and I know the type of diet. DS #2 also stated, It is not normal practice for Dining Room Services staff to hand a CNA a hot dog without verifying which resident gets it, because they all have different diets. If a resident who is on a mechanical soft ground diet, received a regular hot dog that is not on regular, the resident can choke on it. DS #2 further stated that Resident #2 should not have received this hot dog.</p> <p>During an interview on 10/10/24 at 10:58 a.m. with RN #1, she stated that CNA should never have given Resident #2 who is on a mechanical soft ground textured diet, a whole hot dog. RN #1 also confirmed that today, Resident #2 had a breakfast tray in front of him/her and no staff was supervising resident during breakfast in Resident #2's room. RN #1 further stated that she was not in-serviced since Resident #2's choking incident on 9/29/24 and is not aware of any new instruction regarding resident eating in his/her room.</p> <p>During an interview with the Administrator, on 10/10/24 at 11:44am, he stated that an emergency in-service was completed with the 7:00 a.m. - 3:00 p.m. shift and 3:00 p.m. - 11:00 p.m. shift, and not 11:00 p.m. - 7:00 a.m. The administrator also stated that not all nursing staff was in-serviced since the incident on 9/29/24.</p> <p>During a follow up survey with the Administrator on 10/10/24 at 12:14 p.m., the Administrator stated that there was no ticket for always available menu, and that the nursing staff should have confirmed which resident the meal was for. The Administrator further stated that the Bistro staff should have verified which appropriate diet to prevent choking.</p> <p>During an interview with the Education Manager on 10/10/24 at 11:55 a.m., she stated that she had not trained or in-serviced the 11:00 p.m. - 7:00 a.m. shift. The Education Manager confirmed that there is a possibility that the 11:00 p.m. - 7:00 a.m. shift could work on 7:00 a.m. - 11:00 p.m. and 3:00 p.m. - 11:00 p. m. shift. The Education Manager further stated that no 11:00 p.m. - 7:00 a.m. nursing staff was in-serviced since incident occurred on 9/29/24.</p> <p>(continued on next page)</p>		

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<p>F 0808</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During a follow up interview with the Administrator on 10/10/24 at 1:13 p.m., he stated that residents who were on altered diet who do not go to the Bistro, must be supervised. The Administrator stated that Resident #2 should not have been in his/her room with tray table with breakfast in front of him/her unsupervised as observed by surveyor on 10/10/24 at 10:33 a.m. The administrator further stated that Resident #2 had a choking event and should not have had a breakfast plate in front of her unattended.</p> <p>During an interview with Certified Nurse Aide (CNA #2) on 10/18/24 at 3:04 p.m., CNA #2, who was assigned to Resident #2 on 9/29/24, stated that she did not remember the name of the Bistro staff and that she was not a regular staff who gave her the lunch tray for Resident #2 prior to serving the tray to the Resident. CNA #2 stated that when resident requested an item from the alternative, meal, it should be verified by a nurse or dietician. CNA #2 confirmed that she asked neither nurse nor dietician for verification. CNA #2 stated that she used the Point of Care (POC), which guided the care of the residents and had the diet type included. CNA #2 stated that she had been in-serviced on types of diet, and that pictures of the types of diet were in the nursing charting room and was aware of the consistency for Resident #2 as ordered by the doctor. The CNA stated that she received a note with Resident #2's tray to chop hotdog, so she chopped up the hot dog, and gave to Resident #2. CNA #2 confirmed the chopped consistency was not the consistency that was ordered by the doctor for Resident #2 but was mechanical soft ground. When asked, CNA #2 confirmed that Resident #2 should not have received the hot dog in a chopped consistency because it was not safe for the resident, he/she could not properly chew, which was a choking hazard and could aspirate on it.</p> <p>During an interview with the Bistro staff (DS #3) on 10/21/24 at 11:45 a.m., DS #3 stated he was the only staff working in the Bistro on 9/29/24. DS #3 stated that the hot dog was already sent up from the kitchen in an isolation box/ plastic container with resident's name on it. DS #3 further stated that the Bistro staff does not alter any items sent up from the kitchen.</p> <p>A review of the policy titled, Bistro Dining with a Revision date of 11/14, showed, All food is prepared in the main kitchen and delivered to the Bistro kitchens for services. It further stated under Residents who are Unavailable for Bistro Dining, that for residents who are unable to attend scheduled bistro meal service, a tray will be made in the Bistro kitchen according to the Resident's dining slip, and that trays will be delivered by the nursing staff.</p> <p>A review of the policy titled, Therapeutic Diets, with procedure effective date of 8/2/19 and procedure review date of 9/30/24, showed under Policy: A therapeutic diet must be prescribed by the resident's attending physician. It further stated that a therapeutic diet is considered a diet ordered by a physician, practitioner or dietician as part of treatment for a disease or clinical condition, to modify specific nutrients in the diet, or to alter the texture of a diet. If mechanically altered diet is ordered, the provider will specify the texture modification. The following dietary consistencies are available: Regular diet - normal everyday foods of soft/tender texture. Mechanical soft ground - meat and other foods diced to 1/8 inch or restricted to make the food easier to chew and/or swallow.</p> <p>A review of the undated policy titled, Food and Nutrition Services showed: Food and nutrition services staff will inspect food trays to ensure that the correct meal is provided to each resident, and If an incorrect meal is provided to a resident ., nursing staff will report it to the food service manager so that a new food tray can be issued.</p> <p>(continued on next page)</p>		

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<p>F 0808</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>A review of the undated policy titled Ordering off of the Alternate Menu, showed that if a resident ordered an item off the always available menu, their food is then checked against their diet order, texture order, and all allergies. The order is then plugged into an excel spreadsheet for consistency and transparency for the staff. Any questionable items will be emailed to the dietician to be approved or denied before the list goes to the cooks. The final order is then delivered to the cafe for preparation of regular texture items and to the back of the house cook who prepares textures for any modified items. Our lead cooks validate the consistency of any modified texture items.</p> <p>A review of the LCS Operations Procedures &amp; Quality Standards Manual dated LCS 2015, under Therapeutic Menu Planning, showed that Mechanical soft: this diet offers food that are easily chewed and often recommended for patients with digestive problems or chewing and swallowing difficulties. Also, under the same manual under Guidelines for Observing Meal Services, under Posted Mealtimes displayed, Therapeutic diets served correctly - check tray card/menu slip versus menu on board next to steam table versus food served, and Mechanically altered diets served correctly.</p> <p>NJAC 8:39 17.4 (a) (1)(2)</p> <p>8:39 27.1(a)</p>		