

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395560	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/05/2024
NAME OF PROVIDER OR SUPPLIER: MASONIC VILLAGE AT ELIZABETHTOWN		STREET ADDRESS, CITY, STATE, ZIP CODE: ONE MASONIC DRIVE ELIZABETHTOWN, PA 17022		
STATE LICENSE NUMBER: 131502				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0000	INITIAL COMMENT	F 0000		
F 0641	Based on a Medicare/Medicaid Recertification, State Licensure and Civil Rights Compliance survey and an investigation of one complaint completed on December 5, 2024, it was determined that Masonic Village at Elizabethtown was not in compliance with the following requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care and the 28 PA Code, Commonwealth of Pennsylvania Long Term Care Licensure Regulations as it relates to the Health portion of the survey process.	F 0641		
SS=D				

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

TITLE:

(X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395560	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/05/2024
NAME OF PROVIDER OR SUPPLIER: MASONIC VILLAGE AT ELIZABETHTOWN		STREET ADDRESS, CITY, STATE, ZIP CODE: ONE MASONIC DRIVE ELIZABETHTOWN, PA 17022		
STATE LICENSE NUMBER: 131502				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0641 SS=D	Continued from page 1 483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by:	F 0641	<ol style="list-style-type: none"> R97 had no evidence of falls with major injury – her MDS was corrected during the survey. R108's MDS has been corrected November's QM Report was reviewed for residents who had been coded as having had weight loss and falls with major injury. The RNAC and Nutritional Service teams have been re-educated on accurate MDS. Weekly audits will be conducted by the RNAC manager and Nutritional Service manager / designee to confirm accurate MDS in weight loss and falls with major injury for (4) weeks. These audits will be reviewed, trended, and determined for the need for future audits deemed by the QAPI team. 	Completion Date: 12/17/2024 Status: APPROVED Date: 12/16/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395560	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/05/2024	
NAME OF PROVIDER OR SUPPLIER: MASONIC VILLAGE AT ELIZABETHTOWN STATE LICENSE NUMBER: 131502		STREET ADDRESS, CITY, STATE, ZIP CODE: ONE MASONIC DRIVE ELIZABETHTOWN, PA 17022		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0641 SS=D	<p>Continued from page 2</p> <p>Based on clinical record review, it was determined that the facility failed to maintain accurate assessments for two of 35 residents reviewed (Residents 97 and 108).</p> <p>Findings include:</p> <p>Review of Resident 97's Quarterly Minimum Data Set (MDS - periodic assessment of resident care needs) dated November 12, 2024, revealed under Section J - Health Conditions that the resident had two falls with major injury (bone fractures, joint dislocations, closed head injuries, or subdural hematomas) since admission/readmission or the prior assessment.</p> <p>Review of Resident 97's clinical record since the resident's admission to the facility on August 13, 2024, failed to reveal evidence of any falls with major injury.</p> <p>Interview with the Director of Nursing on December 5, 2024, at approximately 11:00 a.m. confirmed</p>	F 0641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395560	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/05/2024	
NAME OF PROVIDER OR SUPPLIER: MASONIC VILLAGE AT ELIZABETHTOWN STATE LICENSE NUMBER: 131502		STREET ADDRESS, CITY, STATE, ZIP CODE: ONE MASONIC DRIVE ELIZABETHTOWN, PA 17022		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0641 SS=D	Continued from page 3 Resident 97 did not have any falls with major injury since being admitted to the facility and that the resident's MDS was coded inaccurately. Review of Resident 108's Quarterly MDS dated November 14, 2024, revealed Resident 108 had a significant weight loss and a significant weight gain. Review of Resident 108's clinical record and weight summaries failed to reveal evidence of significant weight loss. Interview with the Director of Nursing on December 5, 2024 at 10:58 a.m. confirmed Resident 108 did not have a significant weight loss and that Resident 108's Quarterly MDS was coded inaccurately. 28 Pa. Code: 211.5(f) Clinical records 28 Pa. Code: 211.12(d)(1)(5) Nursing services	F 0641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395560	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/05/2024
NAME OF PROVIDER OR SUPPLIER: MASONIC VILLAGE AT ELIZABETHTOWN		STREET ADDRESS, CITY, STATE, ZIP CODE: ONE MASONIC DRIVE ELIZABETHTOWN, PA 17022		
STATE LICENSE NUMBER: 131502				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0740 SS=D	483.40 Behavioral Health Services §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is not met as evidenced by:	F 0740	1. R97 has been seen by the psychologist 2. A comprehensive review has been conducted for any upcoming psychology appointments with appropriate appointment dates 3. The clinic staff has been re-educated on scheduling Behavioral Health appointments in an appropriate time frame. 4. Weekly audits will be conducted by the director of ancillary services to confirm appropriate time frames with Behavioral Health appointments for (4) weeks. These audits will be reviewed, trended, and determined for the need for future audits deemed by the QAPI team.	Completion Date: 12/17/2024 Status: APPROVED Date: 12/16/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395560	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/05/2024	
NAME OF PROVIDER OR SUPPLIER: MASONIC VILLAGE AT ELIZABETHTOWN STATE LICENSE NUMBER: 131502		STREET ADDRESS, CITY, STATE, ZIP CODE: ONE MASONIC DRIVE ELIZABETHTOWN, PA 17022		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0740 SS=D	<p>Continued from page 5</p> <p>Based on clinical record review, it was determined that the facility failed to ensure behavioral health services were offered in a timely manner for one of two residents reviewed for mood and behaviors (Resident 97).</p> <p>Findings include:</p> <p>Review of Resident 97's clinical record revealed the resident was admitted to the facility on August 13, 2024, with diagnoses including, but not limited to, anxiety and other symptoms and signs involving emotional state.</p> <p>Review of Resident 97's progress notes revealed a nurse's note on August 14, 2024, which stated, "Resident was resting in recliner, resident was crying earlier stating that she was ready to die, she does not want to harm herself but just ready to die."</p> <p>Further review of Resident 97's progress notes revealed a nurse's note on October 4, 2024, which stated, "I went in at 10am. to give meds. and</p>	F 0740		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395560	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/05/2024
NAME OF PROVIDER OR SUPPLIER: MASONIC VILLAGE AT ELIZABETHTOWN		STREET ADDRESS, CITY, STATE, ZIP CODE: ONE MASONIC DRIVE ELIZABETHTOWN, PA 17022		
STATE LICENSE NUMBER: 131502				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0740 SS=D	Continued from page 6 resident was still in bed. She said 'I just want to die, I can't get up in the mornings anymore'. I asked her if she feels depressed, she said yes. [Physician] was here and notified." Review of Resident 97's physician progress notes revealed a physician note on October 4, 2024, which stated: "I spoke with nursing who reports that patient sometimes wakes up [stating] she does not want to live anymore, and does not want to get out of bed." Further review of the physician note revealed: "I did offer her medication, which is not inclined to take, and I agree with her. She does like to have good conversations and appreciates when someone takes the time to listen to her, and I think this will be the best treatment for her." Review of Resident 97's physician's orders revealed an order dated October 18, 2024, for behavioral health (psychology) evaluation and treatment for increased depression and anxiety. Review of Resident 97's progress notes revealed a	F 0740		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395560	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____	(X3) DATE SURVEY COMPLETED: 12/05/2024
NAME OF PROVIDER OR SUPPLIER: MASONIC VILLAGE AT ELIZABETHTOWN		STREET ADDRESS, CITY, STATE, ZIP CODE: ONE MASONIC DRIVE ELIZABETHTOWN, PA 17022		
STATE LICENSE NUMBER: 131502				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE)	(X5) COMPLETE DATE
F 0740 SS=D	Continued from page 7 Behavioral Note from the psychologist on November 27, 2024 to evaluate the resident for depression and anxiety. The delay in obtaining a psychology evaluation for Resident 97 was discussed with and confirmed with the Director of Nursing on December 5, 2024, at approximately 9:30 a.m. 28 Pa Code 211.12(d)(1)(3)(5) Nursing Services	F 0740		



Certified End Page

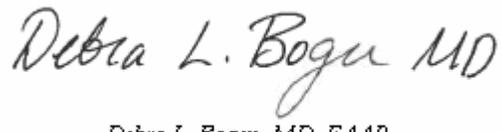
MASONIC VILLAGE AT ELIZABETHTOWN

STATE LICENSE NUMBER: 131502

SURVEY EXIT DATE: 12/05/2024

I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey


Jeanne Parisi
Deputy Secretary for Quality Assurance


Debra L. Bogen, MD, FAAP
Secretary of Health



**Pennsylvania
Department of Health**

THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY