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	01/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Masonic Village at Burlington	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)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Complaint # 405694Based on interviews, review of medical records, and review of other pertinent facility documents on 1/22/26 and 1/28/2026, it was determined that the facility failed to honor and communicate a cognitively intact resident's expressed preference regarding personal care providers, resulting in the resident receiving care inconsistent with their stated preferences. This deficient practice was identified for 1 of 4 residents reviewed (Resident #1), as evidenced by the following:According to the admission Record (AR), Resident #1 was admitted with diagnoses that included but were not limited to: left shoulder fracture.According to the Minimum Data Set (MDS), an assessment tool dated 5/7/2025, revealed that resident #1 had a Brief Interview for Mental Status (BIMS) score of 13 out of 15, which indicated the resident was cognitively intact. A review of the document titled Verbal Coaching/Education dated 5/23/25 addresses Registered Nurse (RN)#1 and revealed REASON FOR Coaching/Education: Team member was notified by resident [Resident #1] that [they] would not like any male caregivers on 5/18/25. Nurse informed [Resident #1] she would ensure [Resident #1] did not receive any male caregivers.Review of Resident #1's medical record revealed no documentation of Resident #1's preferences and the preference was not reflected in the care plan on 5/18/25 or relayed in shift-to-shift communication. As a result, on 5/19/25, a male Certified Nursing Assistant (CNA)#1 provided care to Resident #1. During an interview on 1/28/2026 at 11:43 A.M., with the Licensed Nursing Home Administrator (LNHA), in the presence of the Director of Nursing (DON), the LNHA states we were unaware of the preference request until the investigation occurred.the nurse did not follow [Resident #1's] preferences at the time she was notified. The LNHA confirmed that the failure to communicate the resident's preference occurred at the nursing level and acknowledged that the facility's policy states residents are allowed to choose providers of healthcare services consistent with their interests, values and personal care needs. A review of the facility's policy dated August 2022, titled Resident Self Determination and Participation reveals under Policy Interpretation and Implementation 1. Each resident is allowed to choose .healthcare providers, that are consistent with his or her interests, values, assessments and plans of care, including: b. personal care needs. d. providers of healthcare services.

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

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	01/28/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Complaint #405694Based on interviews, review of medical records, and review of other pertinent facility documents on 1/22/26 and 1/28/2026, it was determined that the facility failed to notify the New Jersey Department of Health (NJDOH) of an injury of unknown origin, specifically an alleged unwitnessed fall resulting in a hip fracture, as required.This deficient practice was identified for 1 of 4 residents reviewed (Resident #2), as evidenced by the following:According to the admission Record (AR), Resident #2 was admitted with diagnoses that included, but were not limited to, Nontraumatic chronic subdural hematoma.According to the Minimum Data Set (MDS), an assessment tool dated 12/6/2025, Resident #2 had a Brief Interview for Mental Status (BIMS) score of 00, indicating severe cognitive impairment.A review of the Progress Notes (PN) dated 12/11/2025 11:00 P.M., revealed that on 12/11/25 at approximately 2:30 P.M., Resident #2 was found on the floor. The incident was unwitnessed. Further review revealed that on 12/11/25 at approximately 9:30 P.M., Resident #2 was sent to the hospital for further evaluation.A review of the PN dated 12/12/25 at 2:23 A.M., revealed Resident #2 was admitted to the hospital with a left hip fracture. A review of a facility document titled Full QA [quality assurance] Report with a date of 12/11/25 at 2:30P.M. revealed the fall was unwitnessed.During a telephone interview with the RN #2, on 1/28/26 at 10:40 A.M., RN #2 stated the resident #2 was experiencing leg pain, which prompted the physician to order pain medication and an x-ray.Review of facility documentation revealed that an internal incident report was completed; however, there was no evidence that the facility reported the injury of unknown origin to the NJDOH, as required.During an interview on 1/28/2026 at 11:42 A.M., the Director of Nursing (DON) in the presence of the Licensed Nursing Home Administrator (LNHA), stated the facility did not report the incident because it was a fall and was not abuse and therefore did not require reporting to the NJDOH. The LNHA stated that the fall wasn't suspicious in nature and did not need to be reported to the NJDOH.A review of the facility's policy titled Abuse and Neglect with a reviewed date of 3/25/2025, revealed under REPORTING AND RESPONSE 'ABUSE' POLICY REQUIREMENTS: The facility will ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation.are reported immediately, but not later than 2 hours after the allegation is made.NJAC 8:39-4.1(a)8