	-	ID HUMAN SERVICES				FOR	M APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	D. 0938-0391
		. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY PLETED	
		315290	B. WING				C / 12/2024
NAME OF PI	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE	1 00	12/2024
BUCKING	HAM AT NORWOOD, TH	E			00 MCCLELLAN STREET		
		-		N	ORWOOD, NJ 07648		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		FC	000			
	Complaint #s : NJ00 NJ00160750 NJ0017	163446 NJ00163114 74505					
	Census: 160						
	Sample Size: 5						
	42 CFR PART 483, S	SUBSTANTIAL THE REQUIREMENTS OF UBPART B, FOR LONG TIES BASED ON THIS					
•							
LABORATORY	L DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATU	RE		TITLE		(X6) DATE
Electroni	cally Signed						07/08/2024

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.

PRINTED: 10/16/2024

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PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH TAG \$ 000 Initial Comments \$ 000 S 000 S 000 S 000 Complaint #s: NJ00163446 NJ00163114 NJ00160750 NJ00174505 \$ 000 S 000 Initial Comments \$ 000 The facility was not in compliance with the standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, Enforcement of Licensure Regulations. \$ 560 \$ 560 8:39-5.1(a) Mandatory Access to Care \$ 560 (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. 1. The facilit to the staffing ratios were met to maintain the required minimum staff-to-resident ratio as mandated by the State of New Jersey for 14 of 14 day shifts. 1. The facilit No resident levels. The immediate r based on th This deficient practice was evidenced by the following: 2. The facility		(X3) DATE SURVEY COMPLETED C 06/12/2024	
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NJ00160750 NJ00174505 The facility was not in compliance with the standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, Enforcement of Licensure Regulations. S 560 8:39-5.1(a) Mandatory Access to Care \$ 560 (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. \$ 560 This REQUIREMENT is not met as evidenced by: \$ 1. The facility to the staffing ratios were met to maintain the required minimum staff-to-resident ratio as mandated by the State of New Jersey for 14 of 14 day shifts. \$ 1. The facility resident resident of 12/2024, it was determined that the facility failed to ensure staffing ratios were were to maintain the required minimum staff-to-resident ratio as mandated by the State of New Jersey for 14 of 14 day shifts. \$ 2. The facility resident for the staffing residents contained by the following: Reference: New Jersey Department of Health \$ 2. The facility resident contained by the following:			
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with N.J.S.A. (New Jersey Statutes Annotated)3. The Direct30:13-18, new minimum staffing requirements forimplementer	a cannot retroactively respond g levels prior to the survey. were affected by staffing dministrator/DON did an view of the staffing levels State staffing ratios. acknowledged that all ald be affected by the acern. or of Human Resources an expedited on-boarding II new hires. Interviews for		

Electronically Signed

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If continuation sheet 1 of 3

07/08/24

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		Ith (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING:	(X3) DATE SURVEY COMPLETED	
		060232	B. WING		C 06/12/2024
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, ST	ATE, ZIP CODE	06/12/2024
		100 MC	CLELLAN STREE		
BUCKING	HAM AT NORWOOD, TH	IE NORWO	OD, NJ 07648		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLE
S 560	Continued From page	e 1	S 560		
S 560	Governor signed into codified at N.J.S.A. 3 established minimum nursing homes. The effective on 02/01/20 One Certified Nurse <i>J</i> residents for the day One direct care staff residents for the ever fewer than half of all CNAs, and each dire signed in to work as a shall perform nurse a One direct care staff residents for the nigh direct care staff mem CNA and perform CN The surveyor reques 05/26/24 to 06/01/24 The facility was defic residents on 14 of 14 -05/26/24 had 8 CNA day shift, required at -05/27/24 had 9 CNA day shift, required at -05/28/24 had 14 CN day shift, required at -05/29/24 had 10 CN	 a law P.L. 2020 c 112, 30:13-18 (the Act), which is staffing requirements in following ratio(s) were 221: Aide (CNA) to every eight shift. member to every 10 ning shift, provided that no staff members shall be a certified nurse aide and aide duties; and member to every 14 at shift, provided that each aber shall sign in to work as a VA duties. ted staffing for the weeks of and 06/02/24 to 06/08/24. tient in CNA staffing for 4 day shifts as follows: As for 159 residents on the least 20 CNAs. 	S 560	new hires will be conducted immedia and contingent offers will be made. I ads are placed on recruitment sites open positions. The staffing coordin will contact all staff daily for any ope shifts to fill them. The DON/designer review all call-outs daily and proactin make every effort to replace staff members. Licensed nurses from the nursing management team will assis covering shifts as needed. The facili offers bonuses to nurses and CNAs needed. The Director of Human Resources will contact nursing and e schools to recruit nurses and CNAs. Director of Nursing will contact nursi schools to partner to be a training fa for nursing and CNA students and o positions once students graduate. T DON/Designee will monitor staffing daily and document a review of staff weekly for 3 months. 4. The audits will be presented to the Administrator weekly. The audits will discussed at the monthly QAPI mee to determine if continued auditing is needed. Once compliance is achiev 2 consecutive months, the plan will f amended as needed.	Online for ator n e will vely st in ty as CNA The ng cility ffer he ratios fing e I be tings ed, for
	-05/29/24 had 10 CN day shift, required at -05/30/24 had 13 CN day shift, required at -05/31/24 had 11 CN day shift, required at	As for 159 residents on the least 20 CNAs. As for 159 residents on the least 20 CNAs. As for 163 residents on the			

7P0P11

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 060232		(X2) MULTIPLE CO A. BUILDING:			(X3) DATE SURVEY COMPLETED C 06/12/2024	
		B. WING				
AME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	, ZIP CODE		
UCKING	HAM AT NORWOOD, TH	łE	CLELLAN STREET OD, NJ 07648			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLET DATE
S 560	day shift, required at -06/02/24 had 6 CNA day shift, required at -06/03/24 had 11 CN day shift, required at -06/04/24 had 13 CN day shift, required at -06/05/24 had 8 CNA day shift, required at -06/06/24 had 11 CN day shift, required at -06/07/24 had 12 CN day shift, required at	least 20 CNAs. As for 158 residents on the least 20 CNAs. IAs for 158 residents on the least 20 CNAs. IAs for 158 residents on the least 20 CNAs. As for 158 residents on the least 20 CNAs. IAs for 159 residents on the	S 560			

7P0P11

STATE FORM: REVISIT REPORT

	MULTIPLE CONSTRUCTION A. Building		DATE OF REVISIT			
	B. Wing	Y2	7/17/2024	Y3		
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE				
BUCKINGHAM AT NORWOOD, TH	Ε	100 MCCLELLAN STREET				
		NORWOOD, NJ 07648				

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

ITEM		DATE	ITEM		DATE	ITEM		DATE
Y4		Y5	Y4		Y5	Y4		Y5
ID Prefix	S0560	Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	8:39-5.1(a)	Completed	Reg. #		Completed	Reg. #		Completed
LSC		07/08/2024	LSC		-	LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix Reg. #		Correction Completed	ID Prefix Reg. #		Correction	ID Prefix		Correction Completed
LSC			LSC			LSC		
ID Prefix Reg. #		Correction	ID Prefix Reg. #		Correction	ID Prefix		Correction Completed
LSC			LSC			LSC		
REVIEWE	D BY	REVIEWED BY	DATE	SIGNATURE OF SU	IRVEYOR		DATE	
STATE AG		(INITIALS)						
REVIEWED BY CMS RO		DATE	TITLE			DATE		
FOLLOWUP TO SURVEY COMPLETED ON 6/12/2024			R ANY UNCORRECTE		B. WAS A SUMMARY OF T TO THE FACILITY?		5 🗌 NO	