STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315290	A. BUILDING _____ B. WING _____	C 02/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BUCKINGHAM AT NORWOOD, THE	**100 MCCLELLAN STREET NORWOOD, NJ 07648**

(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 DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS COMPLAINT #: NJ161036, NJ161038 CENSUS: 155 SAMPLE SIZE: 4 THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT. F689IJ Based on interviews, medical records reviews, and review of other pertinent facility documentation on 2/3/2023, 2/6/2023, 2/7/2023, and 2/14/2023, it was determined that the facility failed to appropriately supervise and monitor a EX Order 26.4B1 resident (Resident #2), with a known history of EX Order 26.4B1, and EX Order 26.4B1. The facility failed to ensure Resident #2, who has a known diagnosis of EX Order 26.4B1 Classified plan of care was implemented for monitoring the Resident's location every shift and as needed and to document observed behaviors and attempted intervention in the Behavior log, on NJ Exec. Order 26.4.B.1 on the 3-11 shift, at approximately 8:00 p.m. to 8:30 p.m., when the Resident was last seen by Certified Nursing Assistant (CNA #2)	F 000		

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

Electronically Signed | 03/17/2023

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.

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F 000	Continued From page 1 and Licensed Practical Nurse (LPN #2) in the dining room, watching television through approximately 9:30 p.m. when Resident #2 was seen again standing in the hallway by the Nurse's station with EX Order 26.4B1 of the EX Order 26.4B1 by LPN #1. LPN #1 notified LPN #2, the Resident's assigned Nurse, of the injuries. 911 was called, and the Resident was sent to the Emergency Room (ER), admitted, and hospitalized with a EX Order 26.4B1. The facility also failed to follow its policies titled "Abuse, Neglect and Exploitation," "Behavioral Health Services," "Documentation In Medical Record," and "Incident/Accident Reporting." The facility's failure to keep Resident #2 safe on EX Order 26.4B1 placed Resident #2 and all other residents with a history of EX Order 26.4B1 EX Order 26.4B1 EX Order 26.4B1 who require NJ Exec. Order 26:4.b.1 of unknown origin and in an Immediate Jeopardy (IJ) situation. This IJ was identified and reported to the facility's Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) on 2/7/2023 at 2:08 p.m. The Administrator was presented with the IJ template that included information about the issue. This Immediate Jeopardy ran from NJ Exec. Order 26:4.b.1 when Resident #2 was last seen at approximately 8:00 p.m. to 8:30 p.m., through approximately 9:30 p.m. when LPN #1 saw the Resident EX Order 26.4B1. On 2/14/2023, the Surveyors did a revisit to verify the Removal Plan was implemented. The facility implemented the Removal Plan, which included educating Staff on elopement, behavior	F 000		

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F 000	Continued From page 2 monitoring, documenting behaviors, wandering with behaviors, updating the care plan for each Resident, and rounding every two hours. So, the noncompliance remained on [NJ Exec. Order 26:4.b.1] at a lower scope and severity for no actual harm with the potential for more than minimal harm that is not immediate jeopardy.	F 000		
F 656 SS=G	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)-	F 656		3/17/23

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F 656	Continued From page 3 (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Complaint #: NJ161036, NJ161038 Based on interviews, medical records reviews, and review of other pertinent facility documentation on 2/3/2023, 2/6/2023, 2/7/2023, and 2/14/2023, it was determined that the facility failed to ensure care plan interventions were implemented for a resident (Resident #2) who is EX Order 26.4B1 and has a history of EX Order 26.4B1 resulting in the resident being hospitalized with a EX Order 26.4B1. The facility also failed to follow its policy titled "Comprehensive Care Plans" for 1 of 4 residents reviewed for CP (Resident #2). Review of the medical record (MR) was as follows: According to the Admission Record (AR), Resident #2 was admitted to the facility on	F 656	Resident #2 presented with EX Order 26. was sent out to nearest emergency room. Resident #2 sustained a EX Order 26.4B1 with EX Order 26.4B and was admitted and has not returned to the facility. All residents in the facility have the potential to be affected by the deficient practice. The Director of Nursing or designee began conducting random weekly audits on 2/10 on all resident comprehensive care plans. A facility wide audit of all resident comprehensive care plans was implemented. One incomplete care plan was implemented, Ensured all care plans were personalized for each resident, consistent with resident rights that	

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F 656	Continued From page 4 EX Order 26.4B1 with diagnoses which included but were not limited to EX Order 26.4B1 [redacted] Classified Elsewhere. According to the Minimum Data Set (MDS), an assessment tool dated EX Order 26.4B1, Resident # 2 had a Brief Interview of Mental Status (BIMS) score of EX Order 26.4, which indicated the Resident had EX Order 26.4B1. The MDS also showed Resident #2 NJ Exec. Order 26:4.b.1 with all Activities of Daily Living (ADLs). A review of the Resident's Care Plan (CP) initiated on EX Order 26.4B1 revealed under "Focus": that Resident #2 "is an EX Order 26.4B1 AEB (as evidenced by) the Resident EX Order 26.4B1 EX Order 26.4B1, Significantly EX Order 26.4B1 of other residents by entering their room." Under "Goal," indicated "Resident will not leave facility unattended through the review date. Target Date NJ Exec. Order 26:4.b.1 Under "Interventions" included: EX Order 26.4B1 [redacted] by offering pleasant diversions, structured activities, food conversation, television, book, Monitor location every shift and as needed, Document EX Order 26.4B1 and attempted diversional interventions in Behavior log, EX Order 26.4B1 q (every) shift ... Exp EX Order 26.4B1 /Monitor and Document placement of EX Order 26.4B1 q shift. During an interview on 2/3/2023 at 2:12 p.m., LPN #2 assigned to Resident #2 at the time of the NJ Exec. Order 26:4.b.1 incident stated the following:	F 656	includes measurable objectives and timeframes to meet each resident medical, nursing, mental and psychosocial needs that were identified in the residents comprehensive assessments. Facility wide education initiated on 2/6/2023 on abuse, behavior monitoring and care plans. The completion of audits will be monitored by the Director of Nursing or designee weekly for 4 weeks, every two weeks for 2 months and monthly for 3months. Audit findings will be discussed during monthly Quality Assurance /Performance Improvement Committee. QAPI committee will determine if continued auditing is necessary once 100% compliance threshold is met for two consecutive months. This plan will be amended when indicated. Adverse finding swill be immediately addressed. Findings and trends will be reported to QAPI Committee at least quarterly.	

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F 656	Continued From page 5 "Resident #2 was in the Unit dining room, the EX Order 26.4B Nurse, LPN #1, notified me at [the] Nurse's station that something happened to the Resident." LPN #2 explained that he met LPN #1 and Resident #2 in the corridor by the elevator. Resident #2 was EX Order 26.4B1 with EX Order 26.4B1, [a] EX Order 26.4B EX Order 26.4B1." He further stated, "[the] Resident was EX Order 26.4 and could not EX Order 26.4B EX Order 26.4B1 or how it happened. EX Order 26.4B1. The last time I saw him/her was sitting in the dining room at 8:00 p.m.-8:30 p.m. Staff were in there [dining room] monitoring either CNA or a nurse, and other residents were in there, but I don't know what Staff were in there that night. [The] Nurse (RN) brought this to my attention at 9:00 p.m.-9:30 p.m. I don't recall giving him/her meds [medications] or treatment that night. He/She would be EX Order 26.4B1. I'm a float nurse ..." During the same interview, LPN #2 continued to say, "Resident #2 got along with his/her roommate. He/She went into other Resident's rooms. I don't recall behaviors with other residents. When asked if there were any altercations with other residents, LPN #2 stated, "No, I did not notice any altercation between other residents. The Resident has a EX Order 26.4B1 EX Order 26.4 and had it on that night. We monitor all our residents with rounds." The LPN further stated, "rounds are done every hour, every half hour, by the Nurse or aide. We redirect [the Resident] from going into other rooms. The CP says to monitor and Document; then it should be documented in the Nurse's PN on the computer. As far as I know, there is no behavioral	F 656		

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F 656	Continued From page 6	F 656		

monitoring sheet for him/her. I assessed him/her after the incident, Nursing Supervisor, Doctor [Physician] were made aware, and the family was made aware as well. Between 8:30 p.m.-9:30 p.m., I don't know where he/she was sitting or where he/she was between this time. I don't know [if] we are supposed to be monitoring all our residents. It's his/her home. He/She walks freely in his/her home. I don't recall the aides' name who worked with me that night. I saw him/her in the dining room sitting in an individual chair between 8:00 p.m.-8:30 p.m."

During an interview on 2/3/2023 at 3:23 p.m., when the Surveyor asked about the incident with Resident #2, LPN #1 stated, "around 9:00 p.m., after I did med [medication] pass, I saw the Resident standing on the side of the Nurse's station of [EX Order 26.4B1]. He/She [EX Order 26.4B1] for 24 hours, and then I called over to [redacted] Nurse (LPN #1). I didn't hear any yelling prior to seeing the Resident. I didn't hear anything. No other residents were around him/her..." LPN #1 explained to the Surveyors that "We have schedules" of the Staff assigned in the dining room. He stated, "it's either [an] aide or Nurse is in the dining room." However, the facility could not provide the assignment schedule during the survey.

In the same interview, LPN #1 continued to say, "After [the] med pass, I saw him/her, [the] Resident just standing there, took [the] Resident to [EX Order 26.4B1], called ambulance and Supervisor. I asked [the] Resident what happened several times, [Resident] gave different answers, [said] EX Order 26.4B1 [redacted]. I couldn't understand what he/she was saying; he/she

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F 656	Continued From page 7	F 656		

didn't make any sense, [the Resident] story [didn't make any sense]. I called [EX Order 26.4B1] Nurse (LPN #2) to come get him/her. [Resident #2] just stood there. There was [EX Order 26.4B1] on [the] [EX Order 26.4B1] and [a] [EX Order 26.4B1] on the [EX Order 26.4B1] area... No crying, [the] Resident said nothing. I just saw [the] face. I didn't check anywhere else. I didn't assess him/her."

During a telephone interview on 2/6/2023 at 10:44 a.m., when the Surveyor asked the CNA assigned to Resident #2 about the incident, she stated, "I was assigned to the Resident on [NJ Exec. Order 26:4.b.1] Resident was walking around at 3:30 p.m., at 5:00 p.m. eating in the dining room, then at 8:00 p.m., he/she was sitting, watching TV then I was caring for other residents. Then at 9:40 p.m., Nurse (LPN #2) informed me of the incident.

In the same interview, the CNA continued, "in [the] dining room; there's the other aide that works on [EX Order 26.4B1] I don't know the other aide's name. I was on [EX Order 26.4B1] with another aide giving care. I only know what I just told you. You need to talk to the DON. I only documented with my statement." When asked by the Surveyor if she documented on the Behavior Log for Resident #2, the CNA stated for monitoring, we do that, but I don't document on him/her. I only Document shower(s) and baths. If assigned to [a] Resident, document every 15 minutes, but I'd have to be told to do it, but I wasn't told to document [the Resident's] Behavior. The Nurse gives me a report on him/her. I don't know if I can see a care plan for him/her. I don't have access to the CP. We [aides] have just ADLs we document. From 8:00 p.m.- 9:00 p.m., I didn't see patient

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F 656	Continued From page 8 [Resident] because I was providing care. When Surveyor asked the CNA who was monitoring Resident #2 from 8:00 p.m. through 9:00 p.m., I told Nurse, I was giving care ..." A review of Resident #2's MR showed no evidence that the CP was followed for monitoring the Resident's location every shift and as needed; to document observed Behavior and attempted intervention and documented in the Behavior log. Also, there was no evidence provided at the time of the survey that a behavior log was implemented for documentation of the Resident's Behavior. During an interview on 2/7/2023 at 12:30 p.m., the Director of Nursing (DON), in the presence of the Licensed Nursing Home Administrator (LNHA) stated, "I can't say if there was someone [staff] monitoring the residents that day of the incident[redacted]." When asked by the Surveyor if there should be someone watching the residents while in the dining room watching television, the DON said, 'yes, while the patients are in the dining room, someone [CNA /Nurse] should be in the dining room monitoring the resident." The DON further stated, "the purpose of the CP is to be individualized so that we can provide care for the patients." When asked if the CP was followed for Resident #2, the DON responded, "No, the CP was not followed." A review of the facility policy titled "Comprehensive Care Plans" with a revision date 09/2022 revealed the following: Under "Policy": included: "It is the policy of this facility to develop and implement a comprehensive person-centered care plan of each resident,	F 656		

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F 656	Continued From page 9 consistent with resident rights, that includes measurable objectives and timeframe's to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment." Under "Definition:" "Person-centered care" "means to focus on the resident as the locus of control and support the resident in making their own choices and having control over their daily lives." Under "Policy Explanation and Compliance Guidelines ":"...3. The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the Resident's highest practicable physical, mental, and psychosocial well-being ...5. The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS (Minimum Data Set) assessment. 6. The comprehensive care plan will include measurable objectives and time frames to meet the Resident's needs as identified in the Resident's comprehensive assessment. The objectives will be utilized to monitor the Resident's progress. Alternative interventions will be documented as needed ...8. Qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made." N.JA.C.: 8:39-11.2(e)(2) N.J.A.C.: 8.39- 27.1 (a)	F 656		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents.	F 689		3/17/23

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F 689	Continued From page 10 The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: COMPLAINT#: NJ161036, NJ161038 Based on interviews, medical records reviews, and review of other pertinent facility documentation on 2/3/2023, 2/6/2023, 2/7/2023, and 2/14/2023, it was determined that the facility failed to appropriately supervise and monitor a EX Order 26.4B1 resident (Resident #2), with a known history of EX Order 26.4B1 EX Order 26.4B1. The facility failed to ensure Resident #2, who has a known diagnosis of EX Order 26.4B1 Classified plan of care was implemented for monitoring the Resident's location every shift and as needed and to document observed behaviors and attempted intervention in the Behavior log, on NJ Exec. Order 26.4.b.1 on the 3-11 shift, at approximately 8:00 p.m. to 8:30 p.m., when the Resident was last seen by Certified Nursing Assistant (CNA #2) and Licensed Practical Nurse (LPN #2) in the dining room, watching television through approximately 9:30 p.m. when Resident #2 was seen again standing in the hallway by the Nurse's station with EX Order 26.4B1	F 689	Resident #2 presented with EX Order 26.4B EX Order 26.4B1, was sent out to nearest emergency room. Resident #2 sustained a EX Order 26.4B1 with injury and was admitted and has not returned to the facility. All residents in the facility have the potential to be affected by the deficient practice. All current residents were assessed for behaviors and EX Order 26.4B1 risk. All identified resident at risk Mar was evaluated for the presence of a personalized behavior monitoring log in their MAR. Three residents without a log had one added. Care plans were put in place appropriate for the behaviors. The Director of Nursing or designee began conducting random weekly audits from 2/10/2023 on all residents with behavior logs. Facility wide education conducted on abuse, behavior monitoring and care plans. Staff education initiated on 2/6/2023 on how to use the behavior monitoring logs and how to document in the monitoring log and re □ evaluating the care plan to ensure that the interventions	

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F 689	Continued From page 11 of the face by LPN #1. LPN #1 notified LPN #2, the Resident's assigned Nurse, of the injuries. 911 was called, and the Resident was sent to the Emergency Room (ER), admitted, and hospitalized with a EX Order 26.4B1 The facility also failed to follow its policies titled "Abuse, Neglect and Exploitation," "Behavioral Health Services," "Documentation In Medical Record," and "Incident/Accident Reporting." The facility's failure to keep Resident #2 safe on NJ Exec. Order 26:4.b.1 placed Resident #2 and all other residents with a history of EX Order 26.4B1 EX Order 26.4B1 who require NJ Exec. Order 26:4.b.1 of unknown origin and in an Immediate Jeopardy (IJ) situation. This IJ was identified and reported to the facility's Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) on 2/7/2023 at 2:08 p.m. The Administrator was presented with the IJ template that included information about the issue. This Immediate Jeopardy ran from NJ Exec. Order 26:4.b.1 when Resident #2 was last seen at approximately 8:00 p.m. to 8:30 p.m., through approximately 9:30 p.m. when LPN #1 saw the Resident EX Order 26.4B1. On 2/14/2023, the Surveyors did a revisit to verify the Removal Plan was implemented. The facility implemented the Removal Plan, which included educating Staff on elopement, behavior monitoring, documenting behaviors, wandering with behaviors, updating the care plan for each Resident, and rounding every two hours. So, the noncompliance remained on NJ Exec. Order 26:4.b.1 at a lower scope and severity for no actual harm with the	F 689	are updated for residents who require monitoring and or supervision. The completion of audits will be monitored by the Director of Nursing or designee weekly for 4 weeks, every two weeks for 2 months and monthly for 3months. Audit findings will be discussed during monthly Quality Assurance /Performance Improvement Committee. QAPI committee will determine if continued auditing is necessary once 100% compliance threshold is met for two consecutive months. This plan will be amended when indicated. Adverse finding swill be immediately addressed. Findings and trends will be reported to QAPI Committee at least quarterly.	

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F 689	Continued From page 12 potential for more than minimal harm that is not immediate jeopardy. This deficient practice was identified for 1 of 4 residents (Resident #2) and was evidenced by the following: According to the Facility Reportable Event (FRE), a New Jersey Department of Health (NJDOH) document used by healthcare facilities to report incidents with an event date of NJ Exec. Order 26:4.b.1 and a "time of event" of 9:30 p.m., revealed the following: On NJ Exec. Order 26:4.b.1 at approximately 9:30 p.m., Resident #2 was noted EX Order 26.4B1 the hallway on the adjacent unit, the Nurse [LPN #1] escorted patient [Resident] back to assigned unit and alerted primary Nurse that patients [Resident's] EX Order 26.4B1 The FRE also revealed Resident #2 initially stated that EX Order 26.4B1 him/her, then later said EX Order 26.4B1 him/her. Resident #2 was sent to the hospital, admitted with a EX Order 26.4B1, and has not returned to the facility. According to the Admission Record (AR), Resident #2 was admitted to the facility on EX Order 26.4B1 with diagnoses which included but were not limited to EX Order 26.4B1 Classified Elsewhere. According to the Minimum Data Set (MDS), an assessment tool dated EX Order 26.4B1, Resident # 2 had a Brief Interview of Mental Status (BIMS)	F 689		

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F 689	Continued From page 13 score of EX Order 26.4, which indicated the Resident had EX Order 26.4B1 The MDS also showed Resident #2 NJ Exec. Order 26:4.b.1 with all Activities of Daily Living (ADLs), and the Resident had a EX Order 26.4B1 alarm. A review of the Resident's Care Plan (CP) initiated on NJ Exec. Order 26:4.b.1 revealed under "Focus": that Resident #2 "is an EX Order 26.4B1 EX Order 26.4B1 AEB (as evidenced by) the Resident EX Order 26.4B1, Significantly intrudes on the privacy of other residents by entering their room." Under "Goal," indicated "Resident will not leave facility unattended through the review date. Target Date NJ Exec. Order 26:4.b.1 Under "Interventions" included: "EX Order 26.4B1 from EX Order 26.4B1 by offering pleasant diversions, structured activities, food conversation, television, book, Monitor location every shift and as needed, Document EX Order 26.4B1 Behavior and attempted diversional interventions in Behavior log, EX Order 26.4B1 r alert: ... EX Order 26.4B1 (every) shift ... Exp EX Order 26.4B1 Monitor and document placement of EX Order 26.4B1 q shift. Further review of Resident #2's CP initiated NJ Exec. Order 26:4.b.1 included under "Focus": Resident #2 "has potential to demonstrate EX Order 26.4B1 and NJ Exec. Order 26:4 r/t (related/to) EX Order 26.4B1 Under "Goal," included: "Resident will NJ Exec. Order 26:4.b.1 through the review date, Target Date NJ Exec. Order 26:4.b.1." Under "Interventions": included: "Analyze of key NJ Exec. Order 26:4.b.1 and document, Assess and address for contributing NJ Exec. Order 26:4.b.1 Evaluate for side effects	F 689		

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F 689	Continued From page 14 of medications, Monitor (every shift). Document observed NJ Exec. Order 26:4.b.1, Monitor/document/report to MD (Medical Doctor) of NJ Exec. Order 26:4.b.1, EX Order 26.4B1 consult as indicated, Room change to from EX Order 26.4B1 to EX Order 26.4B1 EX Order 26.4, Will continue to encourage and provide opportunities for active participation in acts of interest & socialization w (with)/peers." A review of Resident #2's "Incident Reports (IRs)" revealed the following: On NJ Exec. Order 26:4.b.1 at 3:00 a.m., revealed Under "Incident Description (ID),": the Resident was asleep in bed. NJ Exec. Order 26:4.b.1 . The Resident slept well until 3 a.m. (3:00 a.m.). The IR showed the Resident was noted walking in the hallway, holding his/her EX Order 26.4B1 The Nurse asked the Resident to show EX Order 26.4B1 pulled up the long sleeve sweater, and EX Order 26.4B1 was noted in the Resident's arm, with EX Order 26.4B1 and EX Order 26.4B1. Resident #2 was EX Order 26.4B1 EX Order 26.4B1 The IR further showed a nurse asked Resident #2 what happened, but the Resident could not say. He/She was unable to give a Description. The Supervisor and Physician were notified. The Resident was administered EX Order 2 EX Order 26.4B1 . Under "Predisposing Situation Factors": revealed EX Order 26.4B1." Under "Other Info (information) revealed, "Resident is on NJ Exec. Order 26:4.b.1 due to EX Order 26.4B1 (EX Order 26.4B1 ." On NJ Exec. Order 26:4.b.1 at 11:23 p.m., revealed Under "ID": "Nursing Description": Activity aide reported	F 689		

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to the nurse resident's EX Order 26.4B1. No EX Order 26.4B1 was noted. Under "Resident Description,": ... "Notes" dated NJ Exec. Order 26:4.b.1 revealed "Conclusion S/P (status/post) (after) EX Order 26.4B1: Activity aide called the Nurse as she noted a EX Order 26.4B1 to the Resident's EX Order 26.4B1; he/she is able to EX Order 26.4B1 with no c/o [complaint] EX Order 26.4B1 at this time." According to the IR, the NP (Nurse Practitioner) was called and made aware and ordered an EX Order 26.4B1 of the EX Order 26.4B1 r/o (rule/out) EX Order 26.4B1)/family was made aware of above." The IR also included that Resident #2 was awake and EX Order 26.4B1 to place and time/he/she ambulated freely around the unit. He/She would EX Order 26.4B1 into other residents' rooms and be redirected by the Staff not to go into other residents' rooms. Resident #2 has the tendency to EX Order 26.4B1 The Resident has been observed EX Order 26.4B1 as he/she exits the dining room. The Resident receives an EX Order 26.4B1 EX Order 26.4B1] and is at a EX Order 26.4B1 Resident #2 is reminded /redirected often by the Nurse and spoken to not to be wheeling or removing anyone from the dining room, but due to the Resident's EX Order 26.4B1 EX Order 26.4B1; he/she continues to wheel residents into the hallway. The IDCP (interdisciplinary) team met and concluded this EX Order 26.4B1 was not due to any abuse as Resident #2 has been noted to EX Ord EX Order 26.4B1 on the door frame, which caused the EX Order 26.4B1. Further review of the IR showed the NJ Exec. Order 26:4.b.1 were negative for a EX Order 26.4B1 and the Resident continued to deny

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any [redacted]. He/She should not be wheeling the residents out of the DR (Dining Room). The CP was reviewed and updated.

On [redacted] at 10:43 p.m., written by LPN #2 revealed Under "ID": "Nursing Description:" "Unwitnessed occurrence at 9:30 p.m., LPN #1, RN advised LPN #2, LPN that he saw [redacted] resident (Resident #2) ambulating by [redacted] nurse station and brought him/her to [redacted], that is when her Nurse (LPN #2) notice the [redacted] of [Resident 2's] check [redacted] was [redacted] with [redacted]." The IR also showed that Resident #2 spoke another language which was translated by the 2N Nurse (LPN #1). According to the IR, Resident #2 was unsure of how the [redacted] happened. The Resident refused [redacted] assessment and vital signs, and his/her [redacted]. Staff member stood with the Resident in the [redacted] dayroom while Dr. [Physician], Nurse Supervisor, and the Resident's family were made aware. A Doctor's [Physician's] order was received to send Resident #2 to the hospital for evaluation. 911 was called, and Resident #2 was transported via [by] ambulance to the Emergency Room. The Resident seemed his/her normal self, [redacted], and verbally responsive. Able to follow simple commands with little resistance. Under "Resident Description": "Resident advised [redacted] does not know how it happened."

A review of Resident #2's Progress Notes (PNs) revealed the following:

On [redacted] at 7:44 a.m. written by the Licensed Practice Nurse (LPN #3) revealed,

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F 689	Continued From page 17 "Received elder [Resident] in bed. No s/s [signs/symptoms] of EX Order 26.4B1 [,] [Resident] NJ Exec. Order 26:4.b.1 voiced. [Resident] refused to go back to bed [and was] redirected with negative results. [Resident] stayed in [the EX EX Order 26.4B dining room [and] EX Order 26.4B1. Refused x EX Order 26.4B1 (s). EX Order 26.4B1 in place. Will continue to monitor." On NJ Exec. Order 26:4.b.1 at 6:48 a.m. written by LPN #3 revealed, "[Received] Resident in bed asleep no s/s of NJ Exec. Order 26:4.b.1] voiced. [Resident] stayed in his/her bed until 2 a.m. [2:00 a.m.], then [the] [Resident] EX Order 26.4B1) in hallways calms (calm), EX Order 26.4B1 noted. Resident stayed in [the EX Order 26.4B1] dining room watching" a show. The Staff attempted to redirect Resident #2 to his/her room, but the Resident EX Order 26.4B1 On NJ Exec. Order 26:4.b.1 at 8:35 a.m. written by LPN #3 revealed, "Received [Resident] sitting in other Resident room eating fruit. [Resident] refused to go back to his/her room, EX Order 26.4B1 in units, get into other residents' [] room(s), and EX Order 26.4B1 residents' [] EX Order 26.4B1 cart. NJ Exec. Order 26:4.b.1 to redirect and does NJ Exec. Order 26:4.b.1 (s). EX Order 26.4B1 or discomfort EX Order 26.4B1 s per [unit] Staff. After several attempts, [the Resident] agreed to go to EX Order 26.4B1] dining room and stayed there most of [the] shift [,] slept intermittently sitting on a chair. Close monitoring [is] ongoing. Will continue to monitor."	F 689		

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On NJ Exec. Order 26:4.b.1 at 6:41 a.m., written by LPN #3 revealed, "Received [Resident] in bed asleep. [Resident] at 12:30 a.m., [was] noted EX Order 26.4B1 in [the] EX Order 26.4B1 units,[;] [Resident] gets into other residents [‘] room and EX Order 26.4B1 , [;] [Resident] became EX Order 26.4B1 when this Nurse EX Order 26.4B1 as per Staff also attempts to EX Order 26.4B1 that redirected, [Resident] is difficult to redirect and does not follow direction,.... Assist [Resident] to EX Order 26.4B1] dining room. Slept in a chair intermittently. Close monitoring ongoing."

On NJ Exec. Order 26:4.b.1 at 7:13 a.m. written by LPN #3 revealed, "Received [Resident] sitting at the edge of his/her bed. Noted talking with roommate [roommate] in their room, EX Order 26.4B1 in units, get into other residents' [‘] room(s), and EX Order 26.4B1] other residents' [‘] EX Order 26.4B1 . Several attempts to take supplies from [the] medication cart. [Resident] is NJ Exec. Order 26:4.b.1 to redirect and does NJ Exec. Order 26:4.b.1 . Become EX Order 26.4B1 when redirected, EX Order 26.4B1 per [unit] Staff. After several attempts, [Resident] agreed to go back to his/her room (and) slept intermittently[,] sitting on a chair. Close monitoring [is] ongoing. Will continue to monitor."

On NJ Exec. Order 26:4.b.1 at 6:52 a.m., written by LPN #3 revealed, "Received [Resident] in bed asleep. [Resident] at 1:30 a.m. [a.m.] noted EX Order 26.4B1 in [the] EX Order -floor units, [;] [Resident] gets into other residents' room[s] and EX Order 26.4B1 , [Resident] became very EX Order 26.4B1 when this Nurse redirected EX Order 26.4B1 as per[unit] Staff also attempts to EX Order 26.4B1 and

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[redacted] to any staff that redirected, [Resident] is [redacted] to redirect and NJ Exec. Order 26:4.b.1 ... Assist [Resident] to [redacted] dining room. Slept in a chair intermittently. Close monitoring ongoing."

On [redacted] at 7:29 a.m. written by LPN #3 revealed, "[Received Resident] in bed asleep no [redacted] voiced. [Resident] stayed in his/her bed until 2 a.m. [2:00 a.m.], then Resident [redacted] in the hallway calms, no [redacted] noted. Resident stayed in [redacted] dining room talking with other Resident (s), slept intermittently [in] sitting chair, [and attempted] to redirect to his/her room but refused. Will continue to monitor.

On [redacted] at 5:30 a.m. written by LPN #3 revealed, "eceived [Received] [Resident] in [redacted] dining room sitting in a chair, no [redacted] oiced. Resident [redacted] -floor unit. Episode x 1 of disturbing other Resident, redirected with positive results, no c/o [complaint] of [redacted], no [redacted] noted." Resident stayed in the dining room calmly watching... show, slept intermittently sitting in the chair, and was redirected to his/her room with negative results.

On [redacted] at 7:44 a.m. written by LPN #3 revealed, "Received [Resident] in [redacted] dining room sitting in a chair, no [redacted] " Resident [redacted] in the [redacted] unit. Episode x 3 of Resident getting [redacted] when other [Residents] went to the [redacted] dining room, redirected each time with positive results, no [redacted] noted. Resident

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stated in the dining room, he/she was calm, watching [EX Order 26.4B1] show, slept intermittently sitting in the chair, and was redirected to [EX Orde] room several times with negative results. EX Order 26.4B1. Will continue to monitor.

On [NJ Exec. Order 26:4.b.1] at 11:22 p.m., written by the Licensed Practice Nurse (LPN #2), revealed "Unwitnessed occurrence- at 8:30 p.m. [EX Order 26.4B1] Nurse (LPN #1), RN advised [EX Order 26.4B1] nurse (LPN #2) that he saw [EX Order 26.4B1] Resident ambulating by [EX Order 26.4B1]) nurse station and brought him/her to [EX Order 26.4B1]), that is when his/her Nurse (writer) notice the [EX Order 26.4B1] of his/her check [EX Order 26.4B1] was [EX Order 26.4B1] with EX Order 26.4B1 of his/her EX Order 26.4B1 The Resident spoke another language and was translated by [EX Orde] Nurse (LPN #1). Resident stated he/she is unsure of how it happened. The Resident refused EX Order 26.4B1). Resident break [breath] [NJ Exec. Order 26:4.b.1]. Staff member stood with Resident in [ ] dayroom with Doctor. [Physician], Nurse Supervisor, and family made aware. Received Doctor's order to send Resident out for evaluation. 911 was called and transported [the] Resident out to ER via ambulance. Further review of the PN revealed the Resident seemed to be his/her normal self, EX Order 26.4B1. Able to follow simple commands with little resistance. As requested, a follow-up call was given to the family member and advised [EX Orde] mother/father went to the hospital, and we will follow up with EX Order 26.4B1 mother/father status.

On [NJ Exec. Order 26:4.b.1] at 5:15 a.m., the PNs revealed at 5:00 a.m. A call was placed to the hospital regarding the Resident's status. Resident #2 was

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F 689	Continued From page 21 admitted DX (diagnosis): "EX Order 26.4B1." Further review of Resident #2's MR showed no evidence that the CP was followed for monitoring the Resident's location every shift and as needed; to document observed Behavior and attempted intervention and documented in the Behavior log. Also, no evidence was provided during the survey that a behavior log was implemented to document the Resident's Behavior. At the time of the survey, the facility could not provide monitoring sheets or assignment sheets that showed what Staff was assigned to monitor the residents in the dining/day room on NJ Exec. Order 26.4.b.1. During an interview on 2/3/2023 at 2:12 p.m., LPN #2 assigned to Resident #2 at the time of the 1/4/2023 incident stated the following: "Resident #2 was in the EX Order 26.4B1 dining room, the EX Order 26.4B1 Nurse, LPN #1, notified me at [the] Nurse's station that something happened to the Resident." LPN #2 explained that he met LPN #1 and Resident #2 in the corridor by the elevator. Resident #2 was sitting on the bench with EX Order 26.4B1 ." He further stated, "[the] Resident was EX Order 26.4B1 He/she EX Order 26.4B1 The last time I saw him/her was sitting in the dining room at 8:00 p.m.-8:30 p.m. Staff were in there [dining room] monitoring either an aide CNA or a nurse, and other residents were in there, but I don't know what Staff were in there that night. [The] Nurse (RN) brought this to my attention at 9:00 p.m.-9:30 p.m. I don't recall giving him/her meds	F 689		

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[medications] or treatment that night. He/She would be EX Order 26.4B1 . I'm NJ Exec. Order 26 "

During the same interview, LPN #2 continued to say, "Resident #2 got along with his/her roommate. He/She went into other Residents' rooms. I don't recall behaviors with other residents. When asked if there were any altercations with other residents, LPN #2 stated, "No, I did not notice any altercation between other residents. The Resident has a EX Order 26.4B1 EX Order 26.4B1 and had it on that night. We monitor all our residents with rounds." The LPN further stated, "rounds are done every hour, every half hour, by the Nurse or aide. We redirect [the Resident] from going into other rooms." The CP says to monitor and document; then it should be documented in the Nurse's PN on the computer. As far as I know, there is no behavioral monitoring sheet for him/her. I assessed him/her after the incident, Nursing Supervisor, Doctor [Physician] were made aware, and the family was also made aware. He further stated, "between 8:30 p.m.-9:30 p.m.; I don't know where he/she was sitting or where he/she was between this time. I don't know [if] we are supposed to be monitoring all our residents. It's his/her home. He/She walks freely in his/her home. I don't recall the aides' name who worked with me that night. I saw him/her in the dining room sitting in an individual chair between 8:00 p.m.-8:30 p.m."

During an interview on 2/3/2023 at 3:23 p.m., when the Surveyor asked about the incident with Resident #2, LPN #1 stated, "around 9:00 p.m., after I did med [medication] pass, I saw the Resident standing on the side of the Nurse's

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BUCKINGHAM AT NORWOOD, THE	**100 MCCLELLAN STREET NORWOOD, NJ 07648**

(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 DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 23 station of [EX Order 26.4B1]. He/She [EX Order 26.4B1] for 24 hours, and then I called over to [redacted] Nurse (LPN #1). I didn't hear any yelling prior to seeing the Resident. I didn't hear anything..." LPN #1 told the Surveyors that "We have schedules" of the Staff assigned in the dining room. He stated, "it's either [an] aide or Nurse is in the dining room." However, the facility could not provide the assignment schedule during the survey. In the same interview, LPN #1 continued to say, "After [the] med pass, I saw him/her, [the] Resident just standing there, took [the] Resident to [EX Order 26.4B1], called ambulance and Supervisor. I asked [the] Resident what happened several times, [Resident] gave different answers, [said] EX Order 26.4B1. I couldn't understand what he/she was saying; he/she didn't make any sense, [the Resident] story [didn't make any sense]. I called [EX Order 26.4B1] Nurse (LPN #2) to come [to] get him/her. [Resident #2] just stood there. There was [NJ Exec. Order 26:4.b.1] on [the] [EX Order] [EX Order 26] and [a] EX Order 26.4B1 area... No crying, [the] Resident said nothing. [EX Order 26.4B1] [the] [EX Order 26.4] I didn't check anywhere else. I didn't assess him/her." During a telephone interview on 2/6/2023 at 10:44 a.m., when the Surveyor asked the CNA assigned to Resident #2 about the incident, she stated, "I was assigned to the Resident on [NJ Exec. Order 26:4.b.1] Resident was walking around at 3:30 p.m., at 5:00 p.m. eating in the dining room, then at 8:00 p.m., he/she was sitting, watching TV then I was caring for other residents. Then at 9:40 p.m., Nurse (LPN #2) informed me of the incident.	F 689		

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In the same interview, the CNA continued, "in [the] dining room; there's the other aide that works on [redacted]; I don't know the other aide's name. I was on [redacted] with another aide giving care. I only know what I just told you. You need to talk to the DON. I only documented with my statement." When asked by the Surveyor if she documented on the Behavior Log for Resident #2, the CNA stated for monitoring, we do that, but I don't document on the Resident. I only document shower(s) and baths. If assigned to [a] Resident, document every 15 minutes, but I'd have to be told to do it, but I wasn't told to document [the Resident's] Behavior. The Nurse gives me a report on him/her. I don't know if I can see a care plan for him/her. I don't have access to the CP. We [aides] have just ADLs we document. From 8:00 p.m.- 9:00 p.m., I didn't see patient [Resident] because I was providing care. When Surveyor asked the CNA who was monitoring Resident #2 from 8: 00 p.m. through 9:00 p.m., I told [the] Nurse I was giving care." The CNA stated it was only her and the Nurse on the unit. So she assumed the Nurse was monitoring the patient [Resident].

During a second interview on 2/6/2023 at 11:47 a.m., LPN #2 stated, "the only documentation I know for residents is the ADL(s) book; I don't know of a behavioral log; as long as the Resident is in the dining room, there should be Staff in there. The Resident was free to walk in this unit, [redacted] and the other unit, [redacted]. No one was monitoring him/her. I was not aware. I last saw the Resident at 8:00 p.m.-8:30 p.m." When the Surveyor asked him what does the code "[redacted]" mean on the (MAR), the LPN replied, "[redacted]" I don't recall where I saw him/her when he/she

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F 689	Continued From page 25 refused the [9.00 p.m.] medication. If an aide [CNA] went to provide care or take a lunch break, another aide or activities [Staff] would monitor or watch a resident. Another staff should be monitoring him/her. He/She EX Order 26.4B1 to the [other] EX Order 26.4B1 dayroom." During an interview on 2/6/2023 at 12:30 p.m., in the presence of the Administrator, the DON stated, "I know the nurses would monitor behaviors and document in [the] progress notes. The aides [CNAs] would note any behaviors and report it [them] to the Nurse. On the day of [the] incident, [Resident #2] was found in the dining room at 8:30 p.m., [the] last time he/she was seen in [the] dining room." The incident was at approximately 9:30 p.m. The dining room does connect both units. [Resident #2] was seen walking around the unit. Per the documentation, [there was] NJ Exec. Order 26:4.b.1 noted, no need for redirection." In the same interview, the DON stated the Nursing Supervisors and other Nurses stated the patient [Resident] said initially he/she had been EX Order 26.4B1 [someone] EX Order 26.4B1 him/her, then later he/she said someone EX Order 26.4B1 at him/her, always a different story stayed with the patient [Resident], called the Doctor [Physician], [due to the] EX Order 26.4B1, called 911 and sent out to the hospital. It had to have just happened. I don't remember the exact time. Another floor nurse came to help. Both nurses called me. LPN #2 was the Nurse that day. "Normally, the Staff, CNAs take turns and monitor residents in the dining room at that time of night." When the Surveyor asked the DON what Staff was assigned to Resident #2 that day/night, the	F 689		

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Administrator and DON replied, "I can't say who was assigned to the Resident in the dining room that day/night." The DON continued to say, "While the patients [residents] are in the dining room, yes, someone, a CNA usually, [is assigned] at that hour or could be a nurse should be in there."

During a telephone interview on 2/7/2023 at 11:13 a.m., when asked about the behavioral log, the previous Unit Manager/Licensed Practical Nurse (UM/LPN) stated she created the behavioral log when she was the UM so that Staff could document Resident #2's EX Order 26.4B1 Behavior. She explained to the Surveyors that the CNAs documented and signed on the Behavior log every shift. When asked where the binder was located and about documenting in the binder, the UM stated the binder was located at the Nurse's station, and the CNAs would document. She said, "Resident #2 did not stay in one place, the Resident would EX Order 26.4B1 around the unit, and we [Staff] would divert him/her. "If the Resident (Resident #2) went to the elevator or exit, we (Staff) would redirect him/her. Staff will always monitor his/her location during the shift and document any EX Order 26.4B1 behaviors in the Behavior log."

A review of facility policy titled "Abuse, Neglect and Exploitation" dated 9/2022 revealed the following: Under "Policy": included: "It is the policy of this facility to provide protection for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property." Under "Definitions:" included:

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F 689	Continued From page 27 "Staff" includes employees, the medical director, consultants, contractors, volunteers, caregivers who provide care and services to residents on behalf of the facility, students in the facility's nurse aide training program and students from affiliated academic institutions, including therapy, social and activity programs." "Abuse" means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical harm, pain, or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse, including abuse facilitated or enabled through the use of technology." Under "Willful" means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm." ...."Physical Abuse" includes but is not limited to hitting, slapping, punching, biting and kicking. It also includes controlling Behavior through corporal punishment." ..."Neglect" means failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress." Under "Serious Bodily Injury" means an injury involving extreme physical pain; involving substantial risk of death, involving protracted loss or impairment of the function of a bodily member, organ, or mental faculty, requiring medical interventions such as surgery, hospitalization, or physical rehabilitation or an injury resulting from criminal sexual abuse ..."	F 689		

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F 689	Continued From page 28 Under "Mistreatment" means inappropriate treatment or exploitation of a resident." A review of facility policy titled "Behavioral Health Services" dated 9/2022 revealed the following: Under "Policy": included: "It is the policy of this facility that all residents receive care and services to assist him or her to reach and maintain the highest level of mental and psychosocial functioning." Under "Policy Explanation and Compliance Guidelines," included: "1. The facility will ensure that each Resident receives 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. 2. Behavioral health includes a resident's entire emotional and mental health, which includes the prevention and treatment of mental and substance use disorders. 3. The facility must have sufficient Staff who provide direct services to residents with the appropriate competencies and skill sets to provide nursing and related services to assure Resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each Resident determined by resident assessments and individual plans of care and considering the number, acuity, and diagnosis of the facility's resident population. 4. These competencies include but are not limited to knowledge of and appropriate training and supervision for: Caring for residents with mental and psychosocial disorders identified in the facility assessment and implementing non-pharmacological interventions 5. All residents who display or are diagnosed with mental disorders or psychosocial adjustment	F 689		

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difficulty, or have a history of trauma or post-traumatic stress disorder will receive appropriate treatment and services to attain the highest practicable and psychosocial well-being ..."

A review of the facility's policy titled "Documentation In Medical Record" with a revised date 10/2022 revealed the following: Under "Policy": included: "Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate and timely documentation." Under "Policy Explanation and Compliance Guidelines," included: "Policy Explanation and Compliance Guidelines: 1. Licensed Staff and interdisciplinary team members shall document all assessments, observations, and services provided in the Resident's medical record in accordance with state law and facility policy. 2. Documentation shall be completed at the time of service but no later than the shift in which the assessment, observation, or care service occurred. 3. Principles of documentation include, but are not limited to: a. Documentation shall be factual, objective, and Resident centered. i. False information shall not be documented. ii. Record descriptive and objective information based on first-hand knowledge of the assessment, observation, or service provided. iii. Subjective information shall be recorded only as relevant, such as the Resident's verbalizations, in quotation marks. b. Documentation shall be accurate, relevant, and complete, containing sufficient details about the Resident's care and/or

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F 689	Continued From page 30 responses to care." c. Documentation shall be timely and in chronological order. d. Write legibly in black ink. e. Record date and time of entry. f. Sign each entry with name and credentials of the person making the entry. g. Only standardized terminology, acronyms, and symbols may be used. h. Avoid generalizations and vague phrases or expressions." A review of the facility's policy titled "Incident/Accident Reporting" with a revised date of 1/2023, revealed the following Under "Policy" included: "The facility shall ensure that systems are in place whereby resident incidents and accidents are reported, their causes identified when possible and timely interventions are established to reduce the probability of a repeated incident." N.J.A.C.: 8.39- 27.1 (a)	F 689		

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S 000	Initial Comments COMPLAINT # NJ161036, NJ161038 CENSUS: 155 SAMPLE SIZE: 4 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 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: COMPLAINT#: NJ161036, NJ161038 Based on facility document review on 2/3/2023, 2/6/2023, 2/7/2023 and 2/14/2023, it was	S 560	The facility continues to follow a recruitment plan to attract Certified Nurse assistants staff and licensed nurses to meet the ratio requirement. Leadership	3/17/23

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

Electronically Signed — 03/17/23

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S 560	Continued From page 1 determined that the facility failed to ensure staffing ratios were met to maintain the required minimum staff-to-resident ratios as mandated by the State of New Jersey for 14 of 14 Certified Nurse's Aides (CNAs) for Day shifts and 1 of 14 evening shifts. This deficient practice had the potential to affect all residents. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with NJSA (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law PL 2020 c 112, codified as NJSA 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio (s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer of all staff members shall be CNAs and each direct staff member shall be signed into work as a certified nurse aide and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. For the 2 weeks of staffing, 12/25/2022 through 12/31/2022 and 01/01/2023 through 01/07/2023, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts and deficient in total staff for residents on 1 of 14 evening shifts as follows: 12/25/22 had 10 CNAs for 157 residents on the	S 560	has met and will continue to meet on an ongoing basis to identify staffing challenges and areas of improvement for licensed certified nursing needs. All residents in the facility have the potential to be affected by the deficient practice Ongoing efforts to recruit and retain staff are in place. Bonus shifts, referral bonus program and CNA school programs. The facility continues to conduct job fairs with immediate interviews and contingency offers. The facility will began expedited but robust onboarding process to new hires. The DON/designee meets with the staffing coordinator daily to review call outs and facility census vs staffing needs. Facility reached out to nursing schools for possible job fairs on contractual agreement for clinical skills and contingency to hire new graduates. Paid leads on indeed to attract new recruitment. Facility ran list of termed employees that left on good terms in effort to rehire candidates. Sign on bonuses are in place for new full time and part time candidates. The DON/designee will monitor ratios weekly until the requirement is met. The results of the audits will be forwarded to the facility administrator and monthly QAPI committee for further recommendations	

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day shift, required 20 CNAs. (15.70 residents per CNA)
12/26/22 had 11 CNAs for 157 residents on the day shift, required 20 CNAs. (14.27 residents per CNA)
12/26/22 had 15 total staff for 157 residents on the evening shift, required 16 total staff. (10.46 residents per Staff)
12/27/22 had 12 CNAs for 157 residents on the day shift, required 20 CNAs. (13.08 residents per CNA)
12/28/22 had 10 CNAs for 157 residents on the day shift, required 20 CNAs. (15.70 residents per CNA)
12/29/22 had 10 CNAs for 162 residents on the day shift, required 20 CNAs. (16.20 residents per CNA)
12/30/22 had 10 CNAs for 162 residents on the day shift, required 20 CNAs. (16.20 residents per CNA)
12/31/22 had 9 CNAs for 160 residents on the day shift, required 20 CNAs. (17.77 residents per CNA)
01/01/23 had 8 CNAs for 160 residents on the day shift, required 20 CNAs. (20 residents per CNA)
01/02/23 had 11 CNAs for 158 residents on the day shift, required 20 CNAs. (14.36 residents per CNA)
01/03/23 had 9 CNAs for 157 residents on the day shift, required 20 CNAs. (17.44 residents per CNA)
01/04/23 had 8 CNAs for 157 residents on the day shift, required 20 CNAs. (19.62 residents per CNA)
01/05/23 had 11 CNAs for 157 residents on the day shift, required 20 CNAs. (14.27 residents per CNA)
01/06/23 had 13 CNAs for 157 residents on the

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BUCKINGHAM AT NORWOOD, THE	**100 MCCLELLAN STREET NORWOOD, NJ 07648**

(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 DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 3 day shift, required 20 CNAs. (12.07 residents per CNA) 01/07/23 had 10 CNAs for 163 residents on the day shift, required 20 CNAs. (16.30 residents per CNA)	S 560		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315290 (Y1)	A. Building B. Wing (Y2)	3/28/2023 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BUCKINGHAM AT NORWOOD, THE	100 MCCLELLAN STREET NORWOOD, NJ 07648

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, 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 CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0656 Reg. # 483.21(b)(1)(3) LSC	Correction Completed 03/17/2023	ID Prefix F0689 Reg. # 483.25(d)(1)(2) LSC	Correction Completed 03/17/2023	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
2/14/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
060232 Y1	A. Building B. Wing Y2	3/28/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BUCKINGHAM AT NORWOOD, THE	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 Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 03/17/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
2/14/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

 EVENT ID: GDF512