

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

PRINTED: 10/20/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315290		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/20/2025	
NAME OF PROVIDER OR SUPPLIER BUCKINGHAM AT NORWOOD, THE				STREET ADDRESS, CITY, STATE, ZIP CODE 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 #: NJ00184418 Census: 158 Sample Size: 4 The facility is in compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities based on this complaint survey.			F 000			

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

TITLE

(X6) DATE

Electronically Signed

05/15/2025

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.

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 060232	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 03/20/2025
NAME OF PROVIDER OR SUPPLIER BUCKINGHAM AT NORWOOD, THE		STREET ADDRESS, CITY, STATE, ZIP CODE 100 MCCLELLAN STREET NORWOOD, NJ 07648		
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S 000	Initial Comments 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 The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Complaint #: NJ00184418 Based on interviews and review of facility documents on 03/20/25, it was determined that the facility failed to ensure staffing ratios were met for 14 of 14-day shifts reviewed. 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 N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for	S 560	No residents were identified nor immediately affected by the failure to provide minimum staffing levels. All residents will have the potential to be affected by the same deficient practice. The staffing coordinator will inform the DON or designee of any call outs that result in insufficient certified nursing assistant staffing levels. This will be reported as soon as possible. Any staffing deficiencies will be filled prior to the start of the shift with other employees or agency if needed.	5/15/25

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S 560	Continued From page 1 nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified as N.J.S.A. 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 prior to survey from 03/02/2025 to 03/15/2025, the facility was deficient in CNA staffing for residents on 2 of 14 day shifts as follows: On 03/02/25 had 15 CNAs for 157 residents on the day shift, required at least 20 CNAs. On 03/03/25 had 9 CNAs for 157 residents on the day shift, required at least 20 CNAs. On 03/04/25 had 15 CNAs for 157 residents on the day shift, required at least 20 CNAs. On 03/05/25 had 14 CNAs for 157 residents on the day shift, required at least 20 CNAs. On 03/06/25 had 16 CNAs for 161 residents on the day shift, required at least 20 CNAs. On 03/07/25 had 12 CNAs for 161 residents on the day shift, required at least 20 CNAs. On 03/08/25 had 15 CNAs for 161 residents on the day shift, required at least 20 CNAs. On 03/09/25 had 9 CNAs for 165 residents on the	S 560	The DON/designee will report any staffing issues on a daily basis to the administrator or designee. Any findings will be followed up and documented on then reported during the quarterly QAPI meetings for 6 months.	

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S 560	Continued From page 2 day shift, required at least 21 CNAs. On 03/10/25 had 14 CNAs for 164 residents on the day shift, required at least 20 CNAs. On 03/11/25 had 16 CNAs for 164 residents on the day shift, required at least 20 CNAs. On 03/12/25 had 14 CNAs for 164 residents on the day shift, required at least 20 CNAs. On 03/13/25 had 14 CNAs for 160 residents on the day shift, required at least 20 CNAs. On 03/14/25 had 19 CNAs for 160 residents on the day shift, required at least 20 CNAs. On 3/15/25 had 16 CNAs for 160 residents on the day shift, required at least 20 CNAs.	S 560		
S1680	8:39-25.2(b)(1)&(2) Mandatory Nurse Staffing (b) The facility shall provide nursing services by registered professional nurses, licensed practical nurses, and nurse aides (the hours of the director of nursing are not included in this computation, except for the direct care hours of the director of nursing in facilities where the director of nursing provides more than the minimum hours required at N.J.A.C. 8:39-25.1(a)) on the basis of: 1. Total number of residents multiplied by 2.5 hours/day; plus 2. Total number of residents receiving each service listed below, multiplied by the corresponding number of hours per day: Wound care 0.75 hour/day Nasogastric tube feedings and/or gastrostomy 1.00 hour/day	S1680		5/15/25

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S1680	Continued From page 3 Oxygen therapy 0.75 hour/day Tracheostomy 1.25 hours/day Intravenous therapy 1.50 hours/day Use of respirator 1.25 hours/day Head trauma stimulation/advanced neuromuscular/orthopedic care 1.50 hours/day	S1680		

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S1680	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on review of the Nurse Staffing Reports for the weeks of 03/02/2025 and 03/15/2025, it was determined that the facility failed to provide at least minimum staffing levels for 2 of 14 days. The required staffing hours and actual staffing hours are as follows: For the week of 03/02/25 Required Staffing Hours: 428.75 -03/03/25 had 424 actual staffing hours, for a difference of -4.75 hours. For the week of 03/09/25 Required Staffing Hours: 434.50 -03/09/25 had 424 actual staffing hours, for a difference of -10.50 hours.	S1680	Staffing coordinator was educated on the mandatory nurse staffing requirement that the facility shall provide nursing services by registered professional nurses based on the required RN staffing hours on 5/15/25. All residents have the potential to be affected by this deficient practice. The DON/designee will audit weekly the weekly staffing schedules to assure that the required registered professional nurses, licensed practical nurses and nurse aides hours are scheduled appropriately to comply with minimum hours required. The results of the weekly and monthly audits will be submitted to the Quality Assurance and Process Improvement Committee Meeting quarterly for 2 quarters. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting. The next Quality Assurance and Process Improvement Committee Meeting will be held on July 24, 2025.	

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 060232	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 6/13/2025
NAME OF FACILITY BUCKINGHAM AT NORWOOD, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 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	Correction	ID Prefix S1680	Correction	ID Prefix	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. # 8:39-25.2(b)(1)&(2)	Completed	Reg. #	Completed
LSC	05/15/2025	LSC	05/15/2025	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	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	
REVIEWED BY STATE AGENCY ☐		REVIEWED BY (INITIALS)		DATE	
REVIEWED BY CMS RO ☐		REVIEWED BY (INITIALS)		DATE	
FOLLOWUP TO SURVEY COMPLETED ON 3/20/2025		☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			