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 07/14/2023

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	F 000		

A Recertification and Complaint Survey was conducted on behalf of the New Jersey Department of Health.

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 RECERTIFICATION/COMPLAINT VISIT.

Survey Dates: 07/10/23 to 07/14/23

Survey Census: 154

Sample Size: 32

Complaint #'s: NJ160334, NJ160490, NJ145249, NJ151675, and NJ157963.
All complaints were unsubstantiated with no related deficient practices.

On 07/13/23 at 2:59 PM, the facility Administrator, Director of Nursing (DON) and Regional Clinical Operations (RCO) were notified of Immediate Jeopardy (IJ) at F880 at scope and severity of J.

The facility provided an acceptable plan for removal of the immediate jeopardy on 07/14/23 at 1:45 PM. The survey team validated the immediate jeopardy was removed on 07/14/23 at 3:00 PM, following the facility's implementation of the plan for removal of the immediate jeopardy. The deficient practice remained at a scope and severity of D for no actual harm with potential for more than minimal harm, that is not immediate jeopardy,following the removal of the immediate

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

Electronically Signed | 07/31/2023

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F 000	Continued From page 1 jeopardy.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to accurately assess one of 32 residents (Resident (R) 101) NJ Exec Order 26.4b1. Failure to code the "MDS" correctly can lead to inaccurate federal reimbursements and inaccurate assessment and care planning of the resident. Findings include: During observation on 07/10/23 at 3:24 PM, R101 was sitting in the wheelchair located in the resident's room. R101 was observed with NJ Exec Order 26.4b1 [redacted]. A NJ Exec Order 26.4b1 was not observed on the resident. R101 was not interviewable. Review of R101's "Admission Record," located in the "Profile" tab of the electronic medical record (EMR) revealed an admission date of NJ Exec Order 26.4b [redacted] with diagnoses that included history of a NJ Exec Order 26.4b [redacted] Review of R101's electronic quarterly "Minimum Data Set (MDS)," located in the "MDS" tab of the EMR with an Assessment Reference Date (ARD) date of NJ Exec Order 26.4b documented R101 had NJ Ex [redacted]	F 641	Resident number 101 MDS was modified to reflect the NJ Ex.Order 26.4(b)(1) [redacted] An MDS audit was completed on all MDS completed in the last 2 weeks to ensure the coding of all residents with impairments were captured accurately. All residents in the facility have the potential to be affected by the deficient practice. The DON/designee will conduct random weekly audits on all MDS prior to locking and submitting to ensure accurate coding. All MDS workers will be educated on accurately coding of all MDS as it relates to impairment on the upper and lower extremities. Audits will be monitored for completion by the Director of Nursing or designee weekly for 4 weeks, every two weeks for 2 months and monthly for 3 months. Audits will be discussed during Quality Assurance Performance Improvement Committee meeting. QAPI Committee will determine if continued auditing is necessary once 100% compliance threshold is met for two consecutive	7/31/23

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F 641	Continued From page 2 On 07/12/23 at 3:08 PM, Licensed Practical Nurse (LPN) 6 was interviewed. LPN6 stated R101 had NJ Exec Order 26 prior to admission and was NJ Exec Order 26.4b1. LPN6 stated R101 was NJ Exec Order 26.4b1 and therefore tried to eat with the left hand. On 07/12/23 at 3:44 PM, the MDS coordinator stated that she did not complete quarterly MDS assessments referenced above, and that the "per diem" MDS Coordinator completed those assessments. The surveyor requested that the MDS coordinator set up an interview with the per diem MDS Coordinator, however, that interview was never set up. Additional information provided by the MDS coordinator was a "Braden Evaluation" dated NJ Exec Order 26.4b that included the following documentation: "NJ Exec Order 26.4b1 ." Review of the "RAI Manual," dated 10/01/19, indicated, "Intent: The intent of G0400 is to determine whether functional limitation in range of motion (ROM) interferes with the resident's activities of daily living or places him or her at risk of injury. . . Item Rationale Health-related Quality of Life o Functional impairment could place the resident at risk of injury or interfere with performance of activities of daily living. Planning for Care o Individualized care plans should address possible reversible causes such as de-conditioning and adverse side effects of medications or other treatments. . . Upper Extremity - includes shoulder, elbow, wrist,	F 641	months. This plan can be amended when indicated. Adverse findings will be immediately addressed. Findings and trends will be reported to QAPI Committee at least quarterly.	

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F 641	Continued From page 3 and fingers." NJAC 8:39-11.1(e)1,2	F 641		
F 656 SS=D	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)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for	F 656		7/31/23

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F 656	Continued From page 4 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: Based on observation, interview, and record review the facility failed to develop and implement a care plan for one of 32 sampled residents (Resident (R) 101) with measurable goals and interventions to care for and manage the resident's NJ Exec Order 26.4b1 . Findings include: During observation of R101 on 07/10/23 at 3:24 PM, resident was sitting in the wheelchair located in the resident's room. R101 was observed with NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1. A NJ Exec Order 26.4b1 was not observed on the resident. Review of R101's "Admission Record," located in the "Profile" tab of the electronic medical record (EMR) revealed an admission date of NJ Exec Order 26.4b with diagnoses that included NJ Exec Order 26.4b1 Review of the NJ Exec Order 26.4b "Physician Progress	F 656	Resident 101 care plan has been completed to reflect measurable goals and intervention to care for and manage her NJ Exec Order 26.4b1 All residents in the facility have the potential to be affected by the deficient practice. The DON/designee will conduct random weekly audits on all residents care plans to ensure care plans are comprehensive and address measurable goals and interventions to care for and manage the resident plan of care during the resident stay. Education was initiated and will continue until all licensed nurses have been in-serviced on completing and updating the resident care plan to ensure there are measurable goals and intervention to reflect the resident plan of care.	

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F 656	Continued From page 5 Notes" located in the "Progress Notes" tab of the EMR revealed a "Rehabilitation Initial Evaluation" which documented that R101 had a history of a NJ Exec Order 26.4b1 Under "Assessment and Plan" the physician documented: NJ Exec Order 26.4b1 to focus on NJ Exec Order 26.4b1, ADLs [activities of daily living], NJ Exec Order 26.4b1 for further management." Review of the NJ Exec Order 26.4b Internal Medicine "Progress Note" located in the "Miscellaneous" tab of the EMR revealed R101 had a NJ Exec Order 26.4b1 and a NJ Exec Order 26.4b1 Review of R101's "Order Summary Report" located in the "Orders" tab of the EMR revealed R101 did not have a physician's order for care and management of the resident's NJ Exec Order 26.4b1 Review of R101's "Care Plan" located in the "Care Plan" tab of the EMR revealed R101 did not have a care plan with measurable goals and interventions for the care and management of R101's NJ Exec Order 26.4b1 . On 07/12/23 at 3:08 PM, Licensed Practical Nurse (LPN) 6 was interviewed. LPN6 stated R101 was NJ Exec Order 26.4b1 and therefore,	F 656	Audits will be monitored for completion by the Director of Nursing or designee weekly for 4 weeks, every two weeks for 2 months and monthly for 3 months. Audits will be discussed during Quality Assurance Performance Improvement Committee meeting. QAPI Committee will determine if continued auditing is necessary once 100% compliance threshold is met for two consecutive months. This plan can be amended when indicated. Adverse findings will be immediately addressed. Findings and trends will be reported to QAPI Committee at least quarterly.	

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F 656	Continued From page 6 tried to eat with the left hand. LPN6 stated R101 was not currently receiving [redacted]. On 07/12/23 at 3:31 PM, additional information was requested from the Director of Nursing related to the care and management of R101's [redacted]. There was no plan for care and/or management of R101's [redacted]. Review of the facility's "Restorative Nursing Program Policy" dated 12/2012 and revised 01/2023, revealed that "restorative nursing programs may be initiated when a resident is discharged from formalized physical, occupation, or speech therapy. Residents may be placed on a restorative program at the discretion of the nursing and/or Interdisciplinary Care Plan (IDCP) team, if appropriate. A resident may be started on a restorative program when he or she is admitted to the facility with restorative needs, whether or not they are a candidate for formalized therapy, or when restorative needs arise during the course of their long-term stay. The restorative nursing program's focus is to maintain mobility and maximize independence with activities of daily living. The decision to discontinue a resident from a particular restorative program must come from the IDCP team. The reason should be documented in the medical record." NJAC 8:39-11.2(e)2 NJAC 8:39-27.1(a)	F 656		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a	F 688		7/31/23

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F 688	Continued From page 7 resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to accurately assess and implement interventions for the care and management of NJ Exec Order 26.4b1 for one of one resident (Resident (R) 101) reviewed for NJ Exec Order 26.4b1. This failure created the potential for further preventable decline in NJ Exec Ord [redacted] Findings include: During observation of R101 on 07/10/23 at 3:24 PM, R101 was sitting in the wheelchair located in the resident's room. R101 was observed with NJ Exec Order 26.4b1 [redacted] and NJ Exec Ord [redacted]. A NJ Exec Order 26.4b1 was not observed on the resident. R101 was not interviewable. Review of R101's "Admission Record," located in the "Profile" tab of the electronic medical record (EMR) revealed an admission date of NJ Exec Order 26.4b	F 688	Resident 101 was reevaluated to assess and implement interventions for the care and management of the NJ Exec Order 26.4b1 [redacted], and to evaluate the appropriateness of a NJ Exec Ord [redacted] to ensure the resident does not experience NJ Exec Order 26.4b1 [redacted] All residents in the facility with a contracture have the potential to be affected by the deficient practice. The Rehab director/designee will conduct random weekly audits on all residents at risk of experiencing a reduction in range of motion, to ensure they have been evaluated and assessed for the appropriateness of a splint or a restorative program to prevent a decrease in range of motion. Education of the rehab director and rehab staff have been implemented	

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F 688	Continued From page 8 with diagnoses that included history of a [redacted] Review of the [redacted] "Physician Progress Notes" located in the "Progress Notes" tab of the EMR revealed the "Rehabilitation Initial Evaluation" which documented R101 had a history of a NJ Exec Order 26.4b1 with a NJ Exec Order 26.4b1. Under "Assessment and Plan" the physician documented: NJ Exec Order 26.4b1 to focus on core NJ Exec Order 26.4b1, ADLs [activities of daily living], NJ Exec Order 26.4b1 as above, will consider [redacted] for further management." Review of R101's "Order Summary Report" located in the "Orders" tab of the EMR revealed the resident had the following physician's order dated [redacted] NJ Exec Order 26.4b1 on when ambulating with nursing staff. NJ Ex.Order 26.4(b)(1) review of the "Order Summary Report" revealed the resident did not have a physician's order for care and/or management of the resident's NJ Exec Order 26.4b1 Review of R101's "Care Plan" located on the "Care Plan" tab of the EMR revealed a care plan	F 688	by the regional director of rehab on how to properly assess and order splints when needed and when to add someone to a restorative program to ensure all residents who enters the facility without limited Range of motion does not experience reduction in range of motion unless the residents clinical condition. Audits will be monitored for completion by the Director of Nursing or designee weekly for 4 weeks, every two weeks for 2 months and monthly for 3 months. Audits will be discussed during Quality Assurance Performance Improvement Committee meeting. QAPI Committee will determine if continued auditing is necessary once 100% compliance threshold is met for two consecutive months. This plan can be amended when indicated. Adverse findings will be immediately addressed. Findings and trends will be reported to QAPI Committee at least quarterly.	

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F 688	Continued From page 9	F 688		

initiated on NJ Exec Order 26.4b for management of a NJ Exec O [redacted]. Further review of the care plan revealed no focus with goals or interventions related to R101's NJ Exec Order 26.4b1 [redacted]

Review of the NJ Exec Order 26.4b Internal Medicine "Progress Note" located in the "Miscellaneous" tab of the EMR revealed that the resident has a NJ Ex.Order 26.4(b)(1) [redacted]

On 07/12/23 at 3:08 PM, Licensed Practical Nurse (LPN) 6 was interviewed. LPN6 stated R101 had a NJ Exec Order prior to admission and was NJ Exec Order 26.4b1. LPN6 stated R101 was NJ Exec Order 26.4b1 and therefore tried to eat with the left hand. LPN6 recalled R101 had NJ Exec Order 26.4b1 in the past, however, R101 was not currently receiving NJ Exec Order 26.4b1.

On 07/12/23 at 3:31 PM, additional information was requested from the Director of Nursing (DON) related to the care and management of R101's NJ Exec Order 26.4b1. There was no plan for care and/or management of R101's NJ Exec Order 26.4b1 [redacted]

During an interview on 07/13/23 at 1:10 PM, the DON revealed R101 was on a NJ Exec Order 26.4b1 program in the past. The DON confirmed R101 did not have a current order for NJ Exec Order 26.4b1re related to R101's NJ Exec Order 26.4b1 [redacted]. The DON did not know why the resident was no longer on a program.

Review of the facility's "Restorative Nursing Program Policy" dated 12/2012 and revised

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F 688	Continued From page 10 01/2023, revealed that "restorative nursing programs may be initiated when a resident is discharged from formalized physical, occupation, or speech therapy. Residents may be placed on a restorative program at the discretion of the nursing and/or Interdisciplinary Care Plan (IDCP) team, if appropriate. A resident may be started on a restorative program when he or she is admitted to the facility with restorative needs, whether or not they are a candidate for formalized therapy, or when restorative needs arise during the course of their long-term stay. The restorative nursing program's focus is to maintain mobility and maximize independence with activities of daily living. The decision to discontinue a resident from a particular restorative program must come from the IDCP team. The reason should be documented in the medical record." NJAC 8:39-27.1(a) NJAC 8:39-27.2(m)	F 688		
F 880 SS=J	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880		8/10/23

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F 880	Continued From page 11 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents	F 880		

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(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 880	Continued From page 12 identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, interview, and policy review, the facility failed to clean and disinfect [redacted] per the manufacturer's recommendation. This facility failure to properly clean and disinfect multi-use [redacted] has the potential to increase the likelihood of transmission of [redacted] for two of 30 residents (Resident (R) 351 and R 11) receiving [redacted] On 7/13/23 at 2:59 PM, the Administrator and the Director of Nursing (DON) were notified of immediate jeopardy (IJ) in the following area: at F880-: Infection Control. The Immediate Jeopardy began on 07/13/23 when the licensed nursing staff failed to properly clean and disinfect multi-use [redacted] for R351 observed on 07/12/23 and R11 observed on 07/13/23. The facility provided an acceptable plan for removal of the immediate jeopardy at F880 on 07/14/23 at 1:45 PM. On 07/14/23 at 3:00 PM, the immediacy was removed after the plan was verified to have been implemented. The deficient practice remained at a scope and severity of a D (Isolated, no actual harm with potential for more	F 880	The physician of resident number 351 and resident number 11 were notified of the deficient practice and asked if they wanted to order testing. MD declined and there were no new orders. All residents requiring finger stick glucose monitoring have the potential to be affected by the deficient practice. Education was initiated on 7/13 on disinfecting the glucometer per facility policy with the competency to show return demonstration and comprehension. Education will continue until all nurses have been educated. Hand washing education and competency was completed on 7/13 and will continue until all nursing staff have been educated. The DON/Designee completed a full house audit to identify all residents at risk of any blood borne infections and MD was called and notified of the deficient practice. All glucometers were removed from the med carts and disinfected according to	

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	315290	A. BUILDING _____ B. WING _____	C 07/14/2023

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F 880	Continued From page 13 than minimal harm) The removal plan included: Administrator completed a root cause analysis. Director of Nursing/designee began education on 07/13/23 at 3:30 PM and will continue until education on disinfecting the glucometer per facility policy with the competency to show return demonstration and comprehension and will continue education until all nurses have been educated. Compliance on competencies to determine knowledge will be audited/monitored for completion by the Director of Nursing or designee weekly for four weeks, every two weeks for two months and monthly for three months. Audits will be discussed during Quality Assurance Performance Improvement (QAPI) meeting. Regional Director of Nursing/designee completed hand washing education and competency to show return demonstration and comprehension on 07/13/23 and will continue until all nursing staff have been educated prior to the next shift. The Director of Nursing identified all residents at risk, and those residents requiring blood glucose monitoring. A full house audit was completed on residents receiving blood glucose monitoring to ensure there are no known blood-borne infections with the identified residents. All glucometers were removed from the medication carts and disinfected according to the facility policy on 07/13/23. All medicine carts were disinfected with the Environmental Protection Agency (EPA) approved disinfecting solution. The removal plan was verified through interviews and observations. On 07/14/23, on the 2 North Unit at 2:29 PM; 1 West unit at 2:30 PM; 2 South unit at 2:51 PM; Penthouse unit at 3:00 PM; and 1 South Unit at 3:01 PM licensed nursing staff were	F 880	the facility policy on 7/13. All med carts were disinfected with the Environmental protection agency (EPA) approved disinfecting solution. The medical director was notified of the deficiency. The glucometer disinfectant policy was updated. Education will be completed with all new hires on glucometer cleaning with competencies. DON/designee will work with central supplies to ensure the (EPA) solution used to clean the glucometers will be readily available. ICAR completed for infection control recommendations on 8/10/2023. Compliance on competencies to determine knowledge and audits on disinfecting glucometers will be audited/monitored for completion by the DON/designee weekly x 4 weeks, then every 2 weeks for 2 months, then monthly for 3 months. Audits will be discussed during Quality Assurance Performance Improvement Committee meeting. QAPI Committee will determine if continued auditing is necessary once 100% compliance threshold is met for two consecutive months. This plan can be amended when indicated. Adverse findings will be immediately addressed. Findings and trends will be reported to QAPI Committee at least Quarterly. Medication carts cleaning audits will be monthly x 3 months. Audits will be discussed during Quality Assurance	

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F 880	Continued From page 14 interviewed regarding the removal plan and facility expectations for the cleaning/disinfecting of resident glucometers. The staff were able to verbalize the process for cleaning, with the correct number of disinfecting wipes and type, to be used. Findings include: During observation on the One West Unit on 07/12/23 at 4:46 PM, Licensed Practical Nurse (LPN) 2 was observed to remove a multi-use NJ Exec Order 26.4b1 from the medicine cart located in the hallway. The NJ Exec Order 26.4b1 contained a NJ Exec Ord [redacted] which were stored in a zippered pouch. LPN2 took the NJ Exec Order 26.4b1 into R351's room, donned gloves, and performed R351's NJ Exec Order 26.4b1. With her gloves still on, LPN2 returned the NJ Exec Order 26.4b1 and container of NJ Exec Order 26.4b1 to the zippered pouch and left R351's room failing to remove her gloves and perform hand hygiene prior to leaving R351's room. LPN2 placed the NJ Exec Order 26.4b1 on top of the medication cart located in the hallway and removed her gloves and performed hand hygiene at that time. After observing LPN2 document R351's NJ Exec Order 26.4b1 results in the electronic medical record, continued observation revealed LPN2 placed the NJ Exec Order 26.4b1 in the medication cart drawer without cleaning or sanitizing it. During interview via telephone of LPN2 on 7/13/23 at 11:41 AM, LPN2 stated that before use the NJ Exec Order 26.4b1 should be disinfected with a wipe from the purple container (Micro-Kill One Germicidal Alcohol Wipes). After use, she wipes everything before it is used for the next resident. LPN 2 stated one wipe is used to wipe front,	F 880	Performance Improvement Committee meeting. QAPI Committee will determine if continued auditing is necessary once 100% compliance threshold is met for two consecutive months. This plan can be amended when indicated. Adverse findings will be immediately addressed. Findings and trends will be reported to QAPI Committee at least Quarterly. DON/designee will audit central supplies for the correct EPA to ensure supplies are always at hand weekly x 4 weeks, then every 2 weeks for 2 months, then monthly for 3 months. Audits will be discussed during Quality Assurance Performance Improvement Committee meeting. QAPI Committee will determine if continued auditing is necessary once 100% compliance threshold is met for two consecutive months. This plan can be amended when indicated. Adverse findings will be immediately addressed. Findings and trends will be reported to QAPI Committee at least Quarterly. Infection preventionist/DON will oversee all infection control policies/practices per regulations and will monitor results, and report findings to QA meetings. Root Cause Analysis-Five Whys PROBLEM: Glucometers were observed to have not been cleaned properly, causing potential infection control contamination. 1. Staff nurses were unaware of policy or do not recall policy.	

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F 880	Continued From page 15 back, and side of the NJ Exec Order 26.4b1. LPN2 stated gloves should be removed, and hands washed with soap and water after performing a NJ Exec Order 26.4b1 test. LPN2 confirmed that she failed to remove her gloves and sanitize her hands after performing R351's NJ Exec Order 26.4b1 test and prior to leaving the resident's room. LPN2 further confirmed she left R351's room after performing the NJ Exec Order 26.4b1 test and discarded her gloves at the medication cart. LPN2 would not confirm that she failed to clean and sanitize the NJ Exec Order 26.4b1 before placing it back into the medication cart. During an interview on 07/12/23 at 4:54 PM the Penthouse Unit regarding cleaning and disinfection of NJ Exec Order 26.4b1, LPN4 stated that prior to performing a NJ Exec Order 26.4b1, he wipes the NJ Exec Order 26.4b1 with an "alcohol swab" and after performing the NJ Exec Order 26.4b1 test, he wipes the NJ Exec Order 26.4b1 with an "alcohol swab." During an interview on 07/12/23 at 5:16 PM, LPN Unit Manager for the One West Unit (LPN1) stated that after NJ Exec Order 26.4b1 use, staff should clean the NJ Exec Order 26.4b1 with antiseptic bleach wipes and let sit for 1 minute. When asked about the policy and procedure for disinfecting NJ Exec Order 26.4b1, LPN1 was unable to locate it. During observation and interview on 07/13/23 at 7:33 AM, on the One South Unit, LPN5 performed a NJ Exec Order 26.4b1 on R11. After performing the NJ Exec Order 26.4b1 test, LPN5 cleansed the NJ Exec Order 26.4b1 with a Micro-Kill One Germicidal Alcohol Wipe. LPN5 then wrapped the NJ Exec Order 26.4b1 in a Micro-Kill One Germicidal Alcohol Wipe and stated he lets it dry and then puts it away.	F 880	2. Staff nurses did not demonstrate full competency regarding education. 3. Staff nurses did not fully comprehend policy and procedure. 4. Education inconsistent among staff nurses 5. Policy vague and details unknown to nursing leadership ROOT CAUSES(S) A) Lack of understanding of policy B) Failure to demonstrate competency	

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F 880	Continued From page 16	F 880		

Review of residents receiving NJ Exec Order 26.4b1 monitoring provided by the DON on 07/13/23 revealed there were 30 residents in the facility that used shared NJ Exec Order 26.4b1, and there were no residents with a confirmed NJ Exec Order 26.4b1 [redacted], such as NJ Exec Order 26.4b1 [redacted].

Observation of medication carts on 07/12/23, 07/13/23, and 07/14/23, revealed germicidals available for cleaning and disinfecting NJ Exec Order 26.4b1 were: Micro-Kill One Germicidal Alcohol Wipes and Micro-Kill Bleach Germicidal Bleach Wipes. The alcohol wipes kill most pathogens after 1 minute. Continued review of the manufacturer's information revealed the alcohol wipes did not kill clostridioides difficile (C. difficile) spores. The bleach wipes kill most pathogens after one minute, and the C. difficile spore after 3 minutes. Therefore, if a resident has a C. difficile infection, the alcohol wipes were not effective in killing the C. difficile spore placing other residents at risk of contamination.

Review of the manufacturer's guidelines entitled, "Cleaning and Disinfecting Procedures for the Meter" revealed: "Cleaning Instructions: Cleaning is the removal of visible dirt and debris. Whenever your glucose meter is dirty, clean the outside of the meter with a new CaviWipes towelette or an EPA-registered disinfecting wipe. The cleaning process does not reduce the risk for transmission of infectious diseases. Disinfection Instructions: The meter must be disinfected between patient uses by wiping it with a CaviWipe towelette or EPA-registered disinfecting wipe in between tests and be cleaned prior to disinfecting. The Disinfection process reduces the risk of transmitting infectious diseases if it is

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F 880	Continued From page 17 performed properly." Review of the facility's policy and procedure, "Glucometer Disinfection" dated 01/2012, and revised on 05/2023 revealed: Under "Policy Explanation and Compliance Guidelines" "The facility will ensure blood glucometers will be cleaned and disinfected after each use and according to manufacturer's instructions for multi-resident use. If the manufacturers are unable to provide information specifying how the glucometer should be cleaned and disinfected, then the meter should not be used for multiple patients. The glucometers should be disinfected with a wipe pre-saturated with an EPA registered healthcare disinfectant that is effective against, at the minimum, HIV, Hepatitis C and Hepatitis B virus. Glucometers should be cleaned and disinfected after each use and according to manufacturer's instructions regardless of whether they are intended for single resident or multiple resident use." Under "Procedure" the following is included after obtaining blood sampling: "Remove and discard gloves, perform hand hygiene prior to exiting room. Reapply gloves is there is visible contamination of the device or if the resident is HIV or Hepatitis B or C positive. Retrieve (2) disinfectant wipes from container. Using first wipe, clean first to remove heavy soil, blood and/or other contaminants left on the surface of the glucometer. After cleaning, use second wipe to disinfect the glucometer thoroughly with the disinfectant wipe, following the manufacturer's instructions. Discard disinfectant wipe in waste receptacle. Perform hand hygiene." The facility's policy and procedure does not specify whether to use the alcohol wipe or bleach wipe. NJAC 8:39-19.4(a)1	F 880		

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S 000	Initial Comments Census: 154 Sample Size: 32 TYPE OF SURVEY: Recertification and Complaints The facility is not in substantial compliance with all of the standards in the New Jersey Administrative Code 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 provisions of 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: Based on interviews, facility document review, and New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, it was determined that the facility failed to ensure staffing ratios were met. This deficient practice had the potential to affect all residents. Findings included: Reference: New Jersey Department of Health	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 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	7/31/23

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

Electronically Signed | 07/31/23

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S 560	Continued From page 1 (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at 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 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 than half of all staff members shall be certified nurse aides, and each direct staff member shall be signed in to 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 certified nurse aide and perform certified nurse aide duties. 1. For the 2 weeks of Complaint staffing from 05/09/2021 to 05/22/2021, 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: -05/09/21 had 12 CNAs for 161 residents on the day shift, required 20 CNAs. -05/10/21 had 13 CNAs for 161 residents on the day shift, required 20 CNAs. -05/11/21 had 9 CNAs for 160 residents on the day shift, required 20 CNAs.	S 560	potential to be affected by the deficient practice. Ongoing efforts to recruit and retain staff are in place: Bonus shifts, referral bonus program, sign on bonus, 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 meets with the staffing coordinator daily to review call outs and facility census vs staffing needs. 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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S 560	Continued From page 2 -05/12/21 had 14 CNAs for 158 residents on the day shift, required 20 CNAs. -05/13/21 had 14 CNAs for 157 residents on the day shift, required 20 CNAs. -05/14/21 had 16 CNAs for 157 residents on the day shift, required 20 CNAs. -05/15/21 had 13 CNAs for 157 residents on the day shift, required 20 CNAs. -05/16/21 had 11 CNAs for 157 residents on the day shift, required 20 CNAs. -05/17/21 had 11 CNAs for 163 residents on the day shift, required 20 CNAs. -05/18/21 had 16 CNAs for 162 residents on the day shift, required 20 CNAs. -05/19/21 had 15 CNAs for 161 residents on the day shift, required 20 CNAs. -05/20/21 had 16 CNAs for 160 residents on the day shift, required 20 CNAs. -05/21/21 had 16 CNAs for 160 residents on the day shift, required 20 CNAs. -05/21/21 had 15 total staff for 160 residents on the evening shift, required 16 total staff. -05/22/21 had 11 CNAs for 160 residents on the day shift, required 20 CNAs. 2. For the 2 weeks of Complaint staffing from 01/16/2022 to 01/29/2022, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows: -01/16/22 had 13 CNAs for 175 residents on the day shift, required 22 CNAs. -01/17/22 had 13 CNAs for 172 residents on the day shift, required 21 CNAs. -01/18/22 had 10 CNAs for 172 residents on the day shift, required 21 CNAs. -01/19/22 had 13 CNAs for 172 residents on the day shift, required 21 CNAs. -01/20/22 had 14 CNAs for 172 residents on the	S 560		

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day shift, required 21 CNAs.
-01/21/22 had 10 CNAs for 172 residents on the day shift, required 21 CNAs.
-01/22/22 had 12 CNAs for 172 residents on the day shift, required 21 CNAs.

-01/23/22 had 10 CNAs for 159 residents on the day shift, required 20 CNAs.
-01/24/22 had 12 CNAs for 159 residents on the day shift, required 20 CNAs.
-01/25/22 had 12 CNAs for 156 residents on the day shift, required 19 CNAs.
-01/26/22 had 13 CNAs for 156 residents on the day shift, required 19 CNAs.
-01/27/22 had 12 CNAs for 156 residents on the day shift, required 19 CNAs.
-01/28/22 had 13 CNAs for 156 residents on the day shift, required 19 CNAs.
-01/29/22 had 12 CNAs for 158 residents on the day shift, required 20 CNAs.

3. For the 2 weeks of Complaint staffing from 09/11/2022 to 09/24/2022, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts, deficient in total staff for residents on 2 of 14 evening shifts, and deficient in total staff for residents on 1 of 14 overnight shifts as follows:

-09/11/22 had 11 CNAs for 167 residents on the day shift, required 21 CNAs.
-09/11/22 had 11 total staff for 167 residents on the overnight shift, required 12 total staff.
-09/12/22 had 11 CNAs for 167 residents on the day shift, required 21 CNAs.
-09/13/22 had 9 CNAs for 167 residents on the day shift, required 21 CNAs.
-09/14/22 had 12 CNAs for 167 residents on the day shift, required 21 CNAs.
-09/15/22 had 8 CNAs for 169 residents on the day shift, required 21 CNAs.

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S 560	Continued From page 4 -09/16/22 had 11 CNAs for 169 residents on the day shift, required 21 CNAs. -09/17/22 had 9 CNAs for 169 residents on the day shift, required 21 CNAs. -09/17/22 had 15 total staff for 169 residents on the evening shift, required 17 total staff. -09/18/22 had 9 CNAs for 170 residents on the day shift, required 21 CNAs. -09/19/22 had 10 CNAs for 170 residents on the day shift, required 21 CNAs. -09/20/22 had 12 CNAs for 170 residents on the day shift, required 21 CNAs. -09/21/22 had 12 CNAs for 170 residents on the day shift, required 21 CNAs. -09/22/22 had 9 CNAs for 170 residents on the day shift, required 21 CNAs. -09/23/22 had 13 CNAs for 170 residents on the day shift, required 21 CNAs. -09/23/22 had 14 total staff for 170 residents on the evening shift, required 17 total staff. -09/24/22 had 11 CNAs for 170 residents on the day shift, required 21 CNAs. 4. For the 2 weeks of Complaint staffing from 12/18/2022 to 12/31/22, 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: -12/18/22 had 9 CNAs for 156 residents on the day shift, required 19 CNAs. -12/19/22 had 10 CNAs for 153 residents on the day shift, required 19 CNAs. -12/20/22 had 9 CNAs for 153 residents on the day shift, required 19 CNAs. -12/21/22 had 8 CNAs for 153 residents on the day shift, required 19 CNAs. -12/22/22 had 9 CNAs for 153 residents on the day shift, required 19 CNAs.	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060232	A. BUILDING: _____ B. WING _____	C 07/14/2023

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) COMPLETE DATE
S 560	Continued From page 5 -12/23/22 had 13 CNAs for 156 residents on the day shift, required 19 CNAs. -12/24/22 had 9 CNAs for 156 residents on the day shift, required 19 CNAs. -12/25/22 had 10 CNAs for 156 residents on the day shift, required 19 CNAs. -12/26/22 had 11 CNAs for 157 residents on the day shift, required 20 CNAs. -12/26/22 had 15 total staff for 157 residents on the evening shift, required 16 total staff. -12/27/22 had 12 CNAs for 157 residents on the day shift, required 20 CNAs. -12/28/22 had 10 CNAs for 157 residents on the day shift, required 20 CNAs. -12/29/22 had 9 CNAs for 162 residents on the day shift, required 20 CNAs. -12/30/22 had 10 CNAs for 162 residents on the day shift, required 20 CNAs. -12/31/22 had 9 CNAs for 160 residents on the day shift, required 20 CNAs. 5. For the 2 weeks of staffing prior to survey from 06/25/2023 to 07/08/2023, 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: -06/25/23 had 9 CNAs for 151 residents on the day shift, required 19 CNAs. -06/26/23 had 9 CNAs for 150 residents on the day shift, required 19 CNAs. -06/27/23 had 11 CNAs for 148 residents on the day shift, required 18 CNAs. -06/28/23 had 10 CNAs for 148 residents on the day shift, required 18 CNAs. -06/29/23 had 9 CNAs for 148 residents on the day shift, required 18 CNAs. -06/30/23 had 11 CNAs for 148 residents on the day shift, required 18 CNAs.	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060232	A. BUILDING: _____ B. WING _____	C 07/14/2023

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

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S 560	Continued From page 6 -07/01/23 had 10 CNAs for 154 residents on the day shift, required 19 CNAs. -07/02/23 had 10 CNAs for 154 residents on the day shift, required 19 CNAs. -07/02/23 had 14 total staff for 154 residents on the evening shift, required 15 total staff. -07/03/23 had 12 CNAs for 153 residents on the day shift, required 19 CNAs. -07/04/23 had 11 CNAs for 151 residents on the day shift, required 19 CNAs. -07/05/23 had 8 CNAs for 151 residents on the day shift, required 19 CNAs. -07/06/23 had 9 CNAs for 151 residents on the day shift, required 19 CNAs. -07/07/23 had 10 CNAs for 151 residents on the day shift, required 19 CNAs. -07/08/23 had 9 CNAs for 151 residents on the day shift, required 19 CNAs.	S 560		

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 _____	R 09/13/2023

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 Survey Date: 7/14/23 Revisit Date: 9/13/23 Census: 155 Sample Size: 4 An onsite Revisit was conducted to verify the implementation of the facility's POC for the Recertification survey conducted on 7/14/23. The facility was found to be in compliance.	{F 000}		

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

Electronically Signed | 09/25/2023

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.

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	9/13/2023 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 F0641	Correction	ID Prefix F0656	Correction	ID Prefix F0688	Correction
Reg. # 483.20(g)	Completed	Reg. # 483.21(b)(1)(3)	Completed	Reg. # 483.25(c)(1)-(3)	Completed
LSC	07/31/2023	LSC	07/31/2023	LSC	07/31/2023
ID Prefix F0880	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	08/10/2023	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	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
7/14/2023	☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060232	A. BUILDING: _____ B. WING _____	R 09/13/2023

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) COMPLETE DATE
{S 000}	Initial Comments The facility is 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: Repeat Deficiency Based on interviews and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios for the day shift as mandated by the State of New Jersey. This deficient practice was identified for CNA staffing for residents on 14 of 14 days shifts and deficient in total staff for residents on 3 of 14 evening shifts. The findings were as follows: Reference: New Jersey Department of Health (DOH) memo, dated 1/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated)	{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 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. New assigned Recruiter to start recruiting for the difficult area of Norwood new Jersey. Transportation services provided to those	9/25/23

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

Electronically Signed | 09/25/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060232	A. BUILDING: _____ B. WING _____	R 09/13/2023

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

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{S 560}	Continued From page 1 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 2/01/2021: 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 than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA 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. A review of the "Nursing Staffing Report" completed by the facility for the weeks of 08/27/23 through 09/09/23, revealed the staffing to resident ratios did not meet the minimum requirement for one CNA to eight residents for the day shift as documented below: - 08/27/23 had 9 CNAs for 158 residents on the day shift, required at least 20 CNAs. - 08/27/23 had 15 total staff for 158 residents on the evening shift, required at least 16 total staff. - 08/28/23 had 11 CNAs for 158 residents on the day shift, required at least 20 CNAs. - 08/29/23 had 10 CNAs for 158 residents on the day shift, required at least 20 CNAs. - 08/30/23 had 9 CNAs for 158 residents on the day shift, required at least 20 CNAs.	{S 560}	without vehicles or transportation to work. Staffing coordinator/designee to reach out to other sister facilities for facility interchangeable staff who may want to pick up shifts. 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. 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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060232	A. BUILDING: _____ B. WING _____	R 09/13/2023

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

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{S 560}	Continued From page 2 - 08/31/23 had 9 CNAs for 159 residents on the day shift, required at least 20 CNAs. - 09/01/23 had 11 CNAs for 157 residents on the day shift, required at least 20 CNAs. - 09/01/23 had 15 total staff for 157 residents on the evening shift, required at least 16 total staff. -09/02/23 had 8 CNAs for 157 residents on the day shift, required at least 20 CNAs. - 09/02/23 had 15 total staff for 157 residents on the evening shift, required at least 16 total staff. - 09/03/23 had 8 CNAs for 156 residents on the day shift, required at least 19 CNAs. - 09/04/23 had 9 CNAs for 156 residents on the day shift, required at least 19 CNAs. - 09/05/23 had 10 CNAs for 156 residents on the day shift, required at least 19 CNAs. - 09/06/23 had 8 CNAs for 153 residents on the day shift, required at least 19 CNAs. - 09/07/23 had 9 CNAs for 153 residents on the day shift, required at least 19 CNAs. - 09/08/23 had 10 CNAs for 153 residents on the day shift, required at least 19 CNAs. - 09/09/23 had 11 CNAs for 153 residents on the day shift, required at least 19 CNAs. There was no additional information provided.	{S 560}		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
060232 (Y1)	A. Building B. Wing (Y2)	10/2/2023 (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 09/25/2023	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	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	
7/14/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315290	A. BUILDING **01** B. WING _____	C **07/14/2023**

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

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E 000	Initial Comments An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health on 07/11/23. The facility was found to be in compliance with 42 CFR 483.73	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health, Health Facility Survey and Field Operations on 07/11/23 was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy Buckingham at Norwood is a three-story building that was built in 1970. It is composed of Type II protected construction. The facility is divided into 21 - smoke zones. The generator does approximately 30 % of the building per Maintenance Director. The current occupied beds are 154 of 240.	K 000		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available.	K 345		8/28/23

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

Electronically Signed | 08/04/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315290	A. BUILDING **01** B. WING _____	C **07/14/2023**

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

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K 345	Continued From page 1 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure smoke detection sensitivity was checked every alternate year of the facility smoke detectors in accordance with NFPA 72 National Fire Alarm and Signaling Code (2010 Edition) Section 14.4.5.3.2. This deficient practice had the potential to affect all 154 residents. Findings include: A document review of the facility's binder, provided by the Maintenance Director, contained inspection and testing reports for the fire alarm system for the calendar year 2021 and 2022. A review of the facility's fire alarm "Inspection and Testing Reports" dated 03/02/23 revealed no reference to a smoke detection sensitivity test. The fire alarm "Inspection and Testing Reports dated 2022 revealed no reference to a smoke detection sensitivity test. An observation of the facility's smoke detectors on 07/11/23 from 12:00 PM to 3:10 PM revealed smoke detectors were located in the corridors at the smoke barriers, 15 feet from the end of the corridors and 30 feet on center, and other concealed areas throughout the building. During an interview on 07/11/23 at 3:10 PM the Maintenance confirmed the smoke sensitivity testing had not been completed on the smoke detectors. NJAC 8:39-31.1(c), 31.2(e) NFPA 70, 72	K 345	Resident have the potential to be effected by the deficient practice secondary to fire alarm system not alarm properly in case of a fire. Smoke sensitivity testing scheduled for 8/21/2023 The maintenance Director or designee will maintain and review facility binder monthly to ensure all inspections are completed timely. The maintenance director or designee will create a schedule for all required inspections. Facility binder will be reviewed by maintenance and reported to the maintenance director and QAPI committee quarterly for 1 year.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315290	A. BUILDING **01** B. WING _____	C **07/14/2023**

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

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K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on document review, observation and interview, the facility failed to ensure the fire doors were inspected annually in accordance with NFPA 101 Life Safety Code (2012 edition) 7.2.1.15. This deficient practice had the potential to affect all 154 residents. Findings include: A document review of the facility's binder dated 2022 and 2023 provided by the Maintenance Director revealed fire door inspections were not conducted. An observation from 12:00 PM to 3:10 PM confirmed no inspections had been conducted on any of the facilities' fire doors in that the doors lacked the required inspection tags that are to be placed on the door (s) after the inspection.	K 761	All residents have the potential to be effected by deficient practice incase of a fire and fire doors do not operate properly. Maintenance inspected and tested fire doors as part of preventative maintenance. The maintenance director or designee will maintain and review preventative maintenance task sheets. Maintenance director or designee to inspect and test fire doors and smoke doors yearly. Maintenance task sheets will be reviewed by maintenance director or designee and results reported to the administrator and QAPI committee quarterly for 1 year.	8/28/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315290	A. BUILDING **01** B. WING _____	C **07/14/2023**

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
K 761	Continued From page 3 At the time of the observation, the Maintenance Director confirmed the doors had not been inspected. NJAC 8:39-31.2(e) NFPA 80	K 761		
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing	K 918		8/28/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315290	A. BUILDING **01** B. WING _____	C **07/14/2023**

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
K 918	Continued From page 4 the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to ensure the three-year load bank test was completed on the existing emergency generator in accordance with NFPA 110 Standard for Emergency and Standby Power Systems (2010 Edition) Section 4.9.1 This deficient practice had the potential to affect all 154 residents. Findings include: A review of the facility's generator reports for 2022 and 2023, provided by the Maintenance Director, revealed a three-year load bank test had not been completed for the emergency generator. During an interview with the Maintenance Director on 07/11/23 at 2:09 PM, the Maintenance Director confirmed that the three-year load bank test had not been completed on the existing emergency generator. NJAC 8:39-31.2(e), 31.2(g) NFPA 99, 110	K 918	All residents have the potential to be effected by the deficient practice secondary to risk of loss of energy source due to power outage. Three-year load test scheduled for 8/21/2023. The maintenance director or designee will review the facility binder monthly to ensure all inspections and tests are completed timely. Maintenance director or designee to review facility binder and schedule any inspections or tests accordingly. Facility binder will be reviewed by maintenance director or designee and reported to the administrator and QAPI committee quarterly for 1 year.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 315290 Y1	MULTIPLE CONSTRUCTION A. Building 01 - MAIN BUILDING 01 B. Wing Y2	DATE OF REVISIT 9/11/2023 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 Reg. # NFPA 101 LSC K0345	Correction Completed 08/28/2023	ID Prefix Reg. # NFPA 101 LSC K0761	Correction Completed 08/28/2023	ID Prefix Reg. # NFPA 101 LSC K0918	Correction Completed 08/28/2023
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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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 7/14/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?			☐ YES ☐ NO