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 04/23/2021

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: 4/23/21 CENSUS: 162 SAMPLE: 32 (plus 3 closed records) A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey. A COVID-19 Focused Infection Control Survey was conducted in conjunction with the recertification survey. The facility was found not to be in compliance with 42 CFR §483.80 infection control regulations as it relates to the CMS and Centers for Disease Control and Prevention (CDC) recommended practices for COVID-19.	F 000		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to: a.) follow a physician's order with regards to [redacted] medications with parameters for 2 of 32 residents (Resident #43 and #312) reviewed for medications; b.) follow a Dietician's recommendation for 1 of 7 residents (Resident #49) reviewed for nutrition; c.) ensure a physician's order for a [redacted] was	F 658	F 658 Element #1 Resident #43 was assessed by an RN for any adverse effect of the alleged failure to follow physician's orders with regards to [redacted] medication parameters, none was noted. On 4/26/2021, MD for Resident #43 was notified of the medication errors noted	5/31/21

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

Electronically Signed | 05/07/2021

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F 658	Continued From page 1 followed for 1 of 2 residents (Resident # 42) reviewed for Executive Order 26, 4.b.; d.) properly transcribe a physician's order onto the Electronic Medication Record (eMAR) for 1 of 32 residents (Resident # 106); e.) follow up on a Executive Order 26, 4.b. recommendation for a Executive Order 26, 4.b. Executive Order for 1 of 5 residents (Resident # 61); and e.) ensure the correct medication was administered to 1 of 6 residents (Resident #97, non-sampled resident) observed during the Medication Observation Pass. This deficient practice was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case-finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling, and provision of supportive and	F 658	during survey. No new orders were given. ADON, LPN#1 and RN#1 were re-educated by the DON on 4/26/2021 on Medication Administration Policy with emphasis on verifying and documenting hold parameters for specific medications. Resident # 312 was assessed by an RN for any adverse effect of the alleged failure to follow physician's orders with regards to Executive Order 26, 4.b. medication parameters, none was noted. A Clarification Order was completed on 4/15/2021 to reflect the correct supplemental documentation for the Executive Order Executive Order 26, 4.b. medication. Resident #49 was assessed by an RN and evaluated by the Dietician for any adverse effect of the alleged failure to follow the nutritional recommendation, none was noted. Resident #42's Executive Order 26, 4.b. order was updated on Executive Order 26, 4.b. by the nurse in charge. Resident #42 did not have any adverse consequence relating to the absence of the wanderguard. Resident #106 was assessed by an RN for any adverse effect of the alleged failure to properly transcribe a physician's order for an Executive Order 26, 4.b. medication, none was observed. The orders for the Executive Order 26, 4.b. medication for Resident #106 was changed and corrected, as per MD order, on Executive Order 26, 4.b. Resident #61 was assessed by an RN for	

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F 658	Continued From page 2 restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." 1. On 4/13/21 at 12:07 PM, the surveyor observed Resident #43 l asleep on their bed. A review of the resident's Executive O Sheet (an Executive Order 26, 4.b.), reflected that the resident was Executive Order 26, 4.b. [redacted] A review of the Executive Order 2 Executive Order 26, 4.b. Set, an assessment tool used to facilitate the management of care, indicated a Brief Interview for Executive Order 26, 4.b.e Order 26, 4.b. which indicated the resident's Executive Order 26, 4.b. Executive Order 26, 4.b [redacted] A review of the Executive Order 26, 4.b. Order Summary Report with a start date of Executive Order , revealed an order for Executive Order 26, 4.b. Executive Order 26, 4.b. [redacted] The corresponding physician order was transcribed into the Executive Order 26, 4.b. electronic Medication Administration Record (eMAR). Further review of the Executive Order 26, 4.b. eMAR's revealed that nurses signed and reflected a checkmark which means that the medication was administered on the following dates and times below: Date Time SBP	F 658	any adverse effect of the alleged failure to follow a Executive Order 26, 4.b. recommendation, none was observed. MD for Resident #61 was notified of the Executive O recommendation and Executive Order 26, 4.b. was corrected as per MD order. Resident #97 did not receive the Executive Orde Executive Order 26, 4.b. on Executive Order 26, 4.b. . RN#7 was re-educated on the Medication Administration Policy on 4/20/2021 by the Staff Educator. All nurses were re-educated by the DON on 4/23/2021 on policies and protocols for Medication Administration, Transcribing Medication and Dietary Orders, and Following Physician's Orders and Recommendations for GDR. Element #2 All residents have the potential to be affected by the alleged deficient practices. Element #3 All nurses were re-educated by the ADON/Educator on 4/26/2021 on policies and protocols for Medication Administration, Transcribing Medication and Dietary Orders, and Following Physician's Orders and Recommendations for GDR. The ADON/Designee will conduct Medication Pass Observation on 5 nurses weekly x 4 weeks, then 5 nurses monthly x 2 months.	

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F 658	Continued From page 3 Executive Order 26, 4.b. [redacted] On 4/15/21 at 1:58 PM, the surveyors met with the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), Infection Preventionist Nurse (IPN), and made them aware of the above concerns about the medication Executive Order 26, 4.b. Executive Order 26, 4.b. . On 4/19/21 at 12:34 PM, the Assistant Director of Nursing (ADON) informed the surveyors that he sometimes works as a floor nurse and administers medications. The ADON stated that a checkmark in the eMAR meant that the medication was administered and "I'm not sure what would be the code to put it medication was held or not given." He further stated that if a medication was held, the nurse would have to call and notify the doctor and that there should be a note to show that the medication was held. On that same date and time, the ADON acknowledged that he was the nurse that signed the eMAR on Executive Order 26, 4.b. xecutive Order 26, 4.b. . The ADON stated, "I know I did not give the medication on those days because I have to follow the parameters." He further stated that "I don't know why it was a checkmark on both days which means it was administered even though I know I didn't give the medication because of the parameters."	F 658	The Unit Manager/Supervisor will audit 10 resident medical records daily x 2 weeks, then weekly x 6 weeks, then monthly x 7 months. Audit will focus on correct order transcription, correct documentation of hold parameters and following GDR recommendations. Element #4 A Medication Administration Performance Improvement Project (PIP) will be conducted monthly x 6 months by the Clinical Team to ensure compliance and identify trends and opportunities for improvement. Results of the PIP will be presented to the QAA Committee during the Quarterly Meetings.	

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F 658	Continued From page 4 On 4/20/21 at 10:03 AM, the Licensed Practical Nurse (LPN #1) informed the surveyors during a telephone interview that she used "the code number 12 which means out of parameters in the eMAR and it will automatically direct you to the notes that medication was not given due to parameters." LPN #1 further stated, "a checkmark in the eMAR means the medication was administered." On that same date and time, the LPN #1 stated "I did not expand the order for [redacted] in the eMAR" that was why "I did not see the parameter order" and the medication was administered on dates[redacted]. She further stated that there was no negative effect on the resident. On 4/20/21 at 10:11 AM, Registered Nurse#1 (RN#1) informed the surveyor during a telephone interview that "#9 was a code if the blood pressure medication was not administered because it was beyond a parameter order." RN #1 stated that "a checkmark means that the medication was administered." She further stated, "I don't know," when asked by the surveyor why the medication [redacted] was administered on [redacted]. 2. On 4/15/21 at 11:02 AM, the surveyor observed Resident #312 [redacted] The resident informed the surveyor that he/she was in the facility for [redacted] A review of the resident's [redacted] Sheet reflected that the resident was admitted to the facility with [redacted]	F 658		

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Executive Order 26, 4.b. .

A review of the Executive Order 26, 4.b. Order Summary Report revealed an order dated Executive Order 26, 4.b. for Executive Order 26, 4.b. Executive Order 26, 4.b. Executive Order 26, 4.b.

The corresponding physician order was transcribed into the Executive Order 26, 4.b. . The order was signed as administered from Executive Order 26, 4.b. Executive Order 26, 4.b. with the pulse instead of the Executive Order 26, 4.b. documented.

A review of the Executive Order 26, 4.b. Physician's Progress Notes revealed that the resident was Executive Order 26, 4.b. Executive Order 26, 4.b. Executive Order 26, 4.b. and the Executive Order 26, 4.b. .

On 4/15/21 at 11:09 AM, RN#2 showed the surveyor the eMAR order for Executive Order 26, 4.b. and stated "I don't know what happened" why the pulse instead of the Executive Order 26, 4.b. was documented. RN #2 indicated that there was no documented Executive Order 26, 4.b. effect on the resident.

On 4/20/21 at 12:57 PM, the DON informed the surveyors that the facility had no policy related to medication with parameters. There was no additional information provided by the facility.

3. On 4/13/21 at 11:30 AM, the surveyor observed Resident # 49 Executive Order 26, 4.b. . The resident smiled at the surveyor but was Executive Order 26, 4.b. Executive Order 26, 4.b.

A review of the resident's Executive Order 26, 4.b. Sheet reflected

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that the resident was Executive Order 26, 4.b. Executive Order 26, 4.b.

A review of the Executive Orde Annual Executive Order 26, 4.b. revealed Executive Order 26, 4.b. which reflected that the resident's Executive Order 26, 4.b.

A review of the Executive Order 26, 4.b. Order Summary Report showed an order dated Executive Order 26 for Executive Order 26, 4.b. Executive Order 26, 4.b. Executive Order 26, 4.b.

Review of the Executive Order 26, 4.b. electronic Medication Administration Record (eMAR) revealed the above corresponding order.

A review of the Executive Order 26 Executive Order 2 Alert Sheet revealed a recommendation to "D/C [discontinue] Executive Order 26, 4.b. "

On 4/19/21 at 11:30 AM, the surveyor interviewed the dietician from the long-term care side of the facility. She stated that the resident "came over from the Executive Order 26, 4.b. unit in Executive Order 26, 4.b. " and that the resident was Executive Order 26, 4.b. and was on a Executive Order 26, 4.b. but Executive Order 26, 4.b. " the residents Executive Order 26, 4.b. and that the resident had a Executive Order 2 She further stated "whenever I make a recommendation, I fill out a dietary alert sheet which goes into the chart flagged and then

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nursing picks up on it. There was no significant Executive Order 26, 4.b. I should have followed up." The dietician along with the surveyor reviewed the 2/27/21 dietary alert sheet which revealed that a Registered Nurse (RN#3) signed the sheet indicating that nursing "noted" the dietary alert sheet.

On 4/19/21 at 12:51 PM, the surveyor conducted a telephone interview with the Licensed Practical Nurse (LPN#2) who signed the 2/27/21 dietary alert sheet. She stated she knows the resident very well. LPN # 2 stated "I did carry out the recommendation, but I put the order in for Executive Order 26, 4.b., that was an oversight on my end. I confused the acronyms Executive Order 26. Executive Or

On 4/21/21 at 1:45 PM, the surveyors met with the Licensed Nursing Home Administrator (LNHA), Director of Nursing, and the Regional Nurse and discussed the above observations and concerns. The DON stated that the order was fixed on 4/14/21 and the resident was getting the Executive Order 26, 4.b.

A review of an undated facility policy for "Medical Nutrition Therapy: Assessment and Care Planning" provided by the DON, indicated that the Registered Dietician or other clinically qualified nutrition professional's recommendations for changes in the nutrition plan of care will be communicated to the licensed nursing team ...the Registered Dietician will be responsible for ensuring follow up ...of recommended changes.

4. On 4/13/21 at 11:42 AM, the surveyor observed Resident #42 Executive Order 26, 4.b. in the dining

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room socially distanced from other residents and wearing a blue surgical mask. The resident was watching a TV show on an Ipad. The surveyor interviewed RN #4 who stated that the resident needed Executive Order 26, 4.b.

A review of the resident's Executive Order 26, 4.b. Sheet reflected that the resident was Executive Order 26, 4.b.

A review of the Executive Order 26, 4.b. Minimum Data Set, revealed a Executive Order 26, 4.b., which reflected that the resident's Executive Order 26, 4.b. was Executive Order 26, 4.b.

A review of the Executive Order 26, 4.b. Order Summary Report showed an order dated Executive Order 26, 4.b. for Executive Order 26, 4.b. to Executive Order 26, 4.b. every shift for monitoring check for placement and function every shift.

Review of the Executive Order 26, 4.b. electronic Treatment Administration Record (eTAR) revealed the above corresponding order.

Review of the electronic Executive Order 26, 4.b. Evaluation dated Executive Order 26, 4.b. did not indicate a score. Further review of the evaluation indicated that the resident Executive Order 26, 4.b.

Review of the resident's Executive Order 26, 4.b. Care Plan initiated on Executive Order 26, 4.b. revealed the resident "is an Executive Order 26, 4.b. as evidenced by Executive Order 26, 4.b.. Resident Executive Order 26, 4.b.

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Executive Order 26, 4.b." Further review of the care plan indicated an intervention for a Executive Order 26, 4.b. Executive Order to the Executive Order 26, 4.b.

On 4/15/21 at 10:17 AM, the surveyor observed the resident seated in a wheelchair near the nurses station. The resident had an overbed table in front of the wheelchair with an Ipad on it. The surveyor did not observe a Executive Order 26, 4.b. to the residents Executive Order 26, 4.b. Executive Or

On 4/19/21 at 10:40 AM, the surveyor observed the resident seated in a wheelchair near the nurses station. The resident had an overbed table in front of the wheelchair. There was no Executive Order 26 Executive Orde observed in place.

On 4/20/21 at 10:15 AM, the surveyor observed the resident seated in a wheelchair near the nurses station. There was no Executive Order 26, 4.b. observed on the resident. The surveyor interviewed the RN #5 who was the Assistant Director of Nursing working on the unit that day. RN #5 stated that the resident was wearing the Executive Order 26, 4.b. and that the Executive Order 26, 4.b. was checked for placement every shift. The surveyor asked RN #5 to show the surveyor where the resident was wearing the Executive Order 26, 4.b. The RN #5 stated it should be on Executive Order 26, 4.b.. The RN #5 checked the resident's Executive Order 26, 4. . There was no Executive Order 26, 4.b. in place. He then checked the resident's Executive Order 26, 4.b. . There was no Executive Order 2 Executive Orde in place. He proceeded to check the residents Executive Order 26, 4.b.. There was no Executive Order 26, 4.b. in place. RN #5 stated the resident "had it on this morning. Maybe he/she took it off." He then went to the resident's room to look for the Executive Order 26, 4.b. The RN #5 could not find the

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F 658	Continued From page 10 Executive Order 26, 4.b. . He further stated that he will "look into" what happened to the Executive Order 26, 4.b. and get back to the surveyor. On 4/20/21 at 11:30 AM, the surveyor interviewed the CNA who stated, "I don't check the Executive Order 26 Executive Orde the nurses do that." Later, on that same day at approximately 12:00 PM, the RN #5 showed the surveyor the Executive Order 26 Executive Orde and stated the resident "had it in Executive hand the whole time." On 4/20/21 at 1:49 PM, the surveyors met with the LNHA and the DON and discussed the above observations and concerns. There was no additional information provided. A review of an undated facility policy for "Elopements and Wandering Residents" provided by the Regional Nurse, indicated that the facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents, and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk ...the facility is equipped with door locks/alarms to help avoid elopements ...alarms are not a replacement for necessary supervision. Staff are to be vigilant in responding to alarms in a timely manner. 5. On 4/13/21 at 11:31 AM, the surveyor observed Resident #106 in bed, the resident was awake but was Executive Order 26, 4.b. Executive Order 26, ...	F 658		

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A review of Resident #106's Executive Order Sheet (an Executive Order 26, 4.b.), reflected that the resident was Executive Order 26, 4.b.

A review of the Executive Order 1 Executive Order 26, 4.b. Executive an assessment tool used to facilitate the management of care, indicated a Brief Interview for Mental Status Executive Order 26, 4.b. which reflected that the resident's Executive Order 26, 4.b. Executive Order 26, 4.b.

A review of the Executive Order 26, 4.b. Order Summary Report with a start date of , revealed an order for Executive Order 26, 4.b.

The corresponding physician order was transcribed into the Executive Order 26, 4.b. electronic Medication Administration Record (eMAR). Further review of the Executive Order 26, 4.b. eMAR's revealed that nurses signed and reflected a checkmark which means that the nurses were signing for the administration of Executive Order 26, 4.b.:

On 4/20/21 at 1:43 AM, the surveyor inspected the Executive Order 26, Medication cart in the presence of a Registered Nurse (RN). The surveyor found a Bingo Card (medication packaging) that contained Executive Order 26, 4.b. Resident #106. The surveyor interviewed the RN #6 who stated that Executive Order 26, 4.b. did not come in Executive Order 26, 4.b. and that the resident gets one Executive Order 26, 4.b. mg and one Executive Order 26, 4.b. mg in order to come to the Executive Order 26, 4.b. RN #6 further stated

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

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that there should be two separate orders for the Executive Order 26, 4.b. and Executive for the Executive Order 26, to equal the prescribed dose.

6. On 4/13/21 at 12:35 PM, the surveyor observed Resident #61 sitting in a wheelchair on the Executive Order 26, dining room watching a movie on an Executive Orde. The resident was Executive Order 26, 4.b.

A review of Resident #61's admission record revealed that the resident was Executive Order 26, 4.b.

A review of the Executive Order 2 Executive Order 26, 4.b. Set, an assessment tool used to facilitate the management of care, indicated a Executive Order 26, 4.b. Executive Order 26, 4.b. Executive Order 26, 4.b. reflected that the resident's Executive Order 26, 4.b.

A review of the Executive Order 26, 4.b Order Summary Report with a start date of Executive Order, revealed an order for Executive Order 26, 4.b. Executive Order 26, 4.b.

The corresponding physician order was transcribed into the Executive Order 26, 4.b. Further review of the eMAR's revealed that nurses signed and reflected a checkmark which means that the nurses were signing for the administration of Executive Order 26, 4.b.

The surveyor reviewed the facility progress notes which revealed a Physician Progress Note Text: Executive Order 26, 4.b. assessment dated 4/7/21 and

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timed at 8:38 AM. The progress note revealed that the [redacted] recommended a [redacted] the primary physician agrees with the [redacted]. Further review of the resident's medical record revealed no follow up from the primary physician to address the recommended [redacted].

On 4/15/21 at 10:15 AM, the surveyor interviewed RN #6 who stated that when a [redacted] enters his progress notes that it's the nurse's responsibility to follow up with the recommendations. The RN #6 also stated that a nurse should have followed up with the physician regarding Resident #61's [redacted] order. The RN #6 was not able to tell the surveyor why the order was not followed up but told the surveyor that she would reach out to the physician.

On 4/15/21 at 1:30 PM, the surveyor interviewed the DON who stated that they have an evening supervisor who worked the 11-7 shift and it was their responsibility to review the progress notes for the facility residents. The DON was not able to specify why this recommendation was missed by the nursing staff.

7. On 4/19/21 at 9:05 AM, the surveyor observed RN #7 during the medication observation pass prepare a [redacted] capsule for administration for Resident #97. The surveyor observed an order for [redacted] supplement with a plotted time of 9:00 AM. The surveyor stopped RN#7 from administering the wrong medication to Resident #97. The surveyor and RN #7 reviewed the bottle of [redacted] was in

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F 658	Continued From page 14 the ingredients. The surveyor and RN #7 inspected the medication cart and found no [redacted] The surveyor interviewed RN #7 who stated that she was going to administer the wrong medication to the resident. RN #7 stated that the resident should be receiving [redacted] and that she would clarify the order with the physician. On 4/20/21 at 1:30 PM, the surveyor met with the DON, and there was no additional information provided by the facility. A review of the facility's policy "Medication Orders" under number 4. "Medication orders requiring clarification due to duplication, unclear name, dosage, form or route should be confirmed with the prescribing physician." And under number 6. "Medication orders-When recording orders for medication, specify a. The type, route, dosage, frequency, and strength of the medication ordered (i.e., Dilantin 100 mg by mouth three times daily). (Note: A placebo is considered a medication and must also have specific orders NJ 8:39-11.2 (b)	F 658		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent	F 686		5/31/21

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F 686	Continued From page 15 pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to follow a physician's order for an Executive Order 26, 4.b. for a resident with a Executive Order 26, 4.b. This deficient practice was identified for 1 of 2 residents (Resident #49) reviewed for Executive Order 26, 4.b. This deficient practice was evidenced by the following: On 4/13/21 at 11:30 AM, the surveyor observed Resident #49 in Executive Order 26, 4.b. The resident smiled at the surveyor but was Executive Order 26, 4.b. The surveyor did not observe an Executive Order 26, 4.b. in place. On 4/15/21 at 11:50 AM, the surveyor observed the Certified Nursing Assistant (CNA #1) rendering care to the resident. The CNA stated she did not know the resident very well since she was a "floater." The CNA acknowledged that the resident had a Executive Order 26, 4.b. ." The surveyor observed there was no Executive Order 26, 4.b. in place. The CNA #1 acknowledged that the resident did not have an Executive Order 26, 4.b. in place. A review of the resident's Executive Order Sheet (an Executive Order 26, 4.b.), reflected that the resident	F 686	F686 Element #1 Resident #49's Executive Order was re-assessed by the RN/ADON on Executive Order 26, 4.b. for any signs of Executive Order 26, 4.b. none was noted. Resident #49's Executive Order 26, 4.b. order was corrected include checking for placement and function. Element #2 All residents with Executive Order 26, 4.b. order have the potential to be affected by the alleged deficient practice. Element #3 The Unit Manager/Supervisor will audit 5 residents requiring specialty Executive Order 26, 4.b. to ensure that resident has an order proper placement and function according to the Physician's Orders. The audit will be conducted daily x 2 weeks, then weekly x 6 weeks, then monthly x 4months. A Performance Improvement Project (PIP) focusing on pressure injury prevention and management will be conducted	

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F 686	Continued From page 16 was Executive Order 26, 4.b. [redacted] The surveyor reviewed the 2/3/21 Annual Minimum Data Set (MDS) and noted a Brief Interview for Mental Status Executive Order 26, 4.b., which reflected that the resident's cognition was Executive Order 26, 4.b.. Further review of the MDS indicated the resident had a Executive Order 26, 4.b. Executive Order 26, 4.b. . A review of the Executive Order 26, 4.b. Order Summary Report showed an order dated Executive Order 26 for an Executive Order 26, 4.b. Executive Order 26, 4.b. check for presence and functioning every shift. The Order Summary Report also indicated an order dated Executive Orde for Executive Order 26, 4.b. [redacted] Executive Order 26, 4.b. Executive Order 26, 4.b. to Executive Order bed, apply Executive Order 26, 4.b. around Executive Order , cover with border gauze. Further review of the Executive Order 26, 4.b. Order Summary Report showed an order dated Executive Order 26 to Executive Executive Order 26, 4.b. Executive Order 26, 4.b. while in bed every shift. Review of the electronic Treatment Record (eTAR) did not reflect the above order for the Executive Order 26, 4.b.. The eTAR did indicate the order to Executive Order 26, 4.b. and this was signed by the nurses.	F 686	monthly x 6 months by the Clinical Team to ensure compliance and identify trends and opportunities for improvement. Results of the PIP will be presented to the QAA Committee during the Quarterly Meetings.	

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Further review of the resident's medical record indicated the resident was seen by the [Executive Order] doctor on a weekly basis. Review of the weekly [Executive Order 2] assessments revealed the [Executive Order] was debrided by the [Executive Order 8] doctor on [Executive Order 26,].

Review of the [Executive Order 1] [Executive Order] assessment indicated the Executive Order 26, 4.b. [Executive Order 26, 4.b.] ... [Executive Order 26, 4.b.] ... [Executive Order] bed has 5% slough, 95% granulation ... Executive Order 26, 4.b. [redacted]

On 4/19/21 at 11:50 AM, the surveyor observed the resident out of bed in a geri chair inside the resident's room. The surveyor observed a black [Executive Order 26, 4.b.] on the floor in the resident's room. At that same time, the surveyor interviewed CNA #2 who stated that maintenance came with an [Execu] [Executive Order 26, 4] and it is [Executive Order 26,] The CNA #2 stated that he did not pay attention if the [Executive Order 26, 4.b.] was ever there.

On that same day at 12:00 PM, the surveyor interviewed the Registered Nurse who was caring for the resident who stated, "the [Executive Order 26, 4.b.] was new, and maintenance was inflating the [Execu] [redacted] The RN stated she usually works on another unit and could not speak to why the resident did not have an [Executive Order 26, 4.b.] in place and stated every resident with a [Executive Order 26, 4.b.] should have some type of Executive Order 26, 4.b. in place.

On that same day at 12:15 PM, the surveyor interviewed the maintenance director who stated the resident had an [Executive Order 26, 4.b.] before but [Executive Orde

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and nursing put in a request for a new one on 4/16/21. He further stated the new [Executive Order 26, 4.b.] is a Executive Order 26, 4.b. " The surveyor requested to review the nursing request.

Review of the [Executive Order 26] nursing request for a new [Executive Order 26, 4.b.] revealed the request was submitted by the Assistant Director of Nursing (ADON). The comments section indicated "needs [Executive Order 26, 4.b.] Should be one left on [Executive Order 26, 4.b.]

On 4/20/21 at 10:02 AM, the surveyor observed the resident in bed lying on the [Executive Order 26, 4.b.] . The ADON was working on the unit and showed the surveyor the resident's [Executive Order 26, 4.b.] The surveyor observed the Executive Order 26, 4.b. [Executive Order 26, 4.b.] The [Executive Order 26, 4.b.] with Executive Order 26, 4.b. .

On 4/20/21 at 11:38 AM, the surveyor interviewed the ADON who confirmed that he was the one who submitted the nursing request on 4/16/21. He further stated that on 4/16/21, he was working on [Executive Order 26, 4.b.] when a nurse from [Executive Order 26] called him and told him that the [Executive Order 26, 4.b.] wasn't working. The ADON could not provide the name of the nurse who called him on 4/16/21. The ADON could not speak to why the surveyor did not observe an [Executive Order 26, 4.b.] in place on [Executive Order 26] and [Executive Order 26]

On 4/21/21 at 1: 45 PM, the surveyors met with the Licensed Nursing Home Administrator (LNHA), Director of Nursing, and the Regional Nurse and discussed the above observations and concerns. There was no facility policy provided and no additional information provided.

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F 686	Continued From page 19 NJAC 8:39-27.1(e)	F 686		
F 880 SS=E	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: §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	F 880		6/11/21

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F 880	Continued From page 20 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 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 observation, interview, and record review, it was determined that the facility failed to: a.) ensure proper use of personal protective equipment (PPE) for 3 of 4 staff; b.) ensure that workers are knowledgeable of the cleaning chemical used in the workplace for 1 of 7 staff, c.) ensure that staff was aware of proper disposal of used PPE and COVID-19 testing kits for 2 of 3	F 880	F880 Element #1 No residents were affected by the alleged deficient infection control practices. The MDSC/RN was re-educated by the DON on 4/15/2021 on the use of proper Personal Protective Equipment (PPE)	

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F 880	Continued From page 21 COVID-19 testing kits; and d.) perform handwashing/hand hygiene appropriately for 2 of 6 staff in accordance with the Centers for Disease Control and Prevention guidelines for infection control to mitigate the spread of COVID-19. This deficient practice was evidenced by the following: According to the U.S. CDC guidelines Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, updated February 23, 2021, included, "2. Recommended infection prevention and control (IPC) practices when caring for a patient with suspected or confirmed SARS-CoV-2: Personal Protective Equipment-HCP who enter the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to Standard Precautions and use a NIOSH-approved N95 or equivalent or higher-level respirator, gown, gloves, and eye protection. Gowns-put on a clean isolation gown upon entry into the patient room or area. Change the gown if it becomes soiled. Remove and discard the gown in a dedicated container for waste or linen before leaving the patient room or care area. Disposable gowns should be discarded after use. Collection of Diagnostic Respiratory Specimens: When collecting diagnostic respiratory specimens (e.g. nasopharyngeal or nasal swab) from a patient with possible SARS-CoV-2 infection, the following should occur: specimen collection should be performed in a normal examination room with the door closed; HCP in the room should wear an N95 or equivalent or higher-level respirator, eye	F 880	when performing COVID-19 testing, disinfection protocol and the proper disposal of test kits and PPE. The ADON was re-educated by the DON on 4/19/2021 on the use of proper Personal Protective Equipment (PPE) when performing COVID-19 testing. The Physical Therapy Assistant was re-educated by the DON on 4/13/2021 on the proper disposal of PPE for residents in the Observation unit. The ADON was re-educated by the DON on 4/20/2021 on the use of proper Personal Protective Equipment (PPE) when in the Observation unit. The ADON was re-educated by the DON on 4/20/2021 on the use of proper Personal Protective Equipment (PPE) when in the Observation unit. LPN observed during medication pass performed a Handwashing Competency under the supervision of the DON on 4/21/2020. Element #2 All residents have the potential to be affected by the alleged deficient practices. Element #3 A Root Cause Analysis was conducted by the Infection Control and Prevention Committee it was determined that the alleged infection control deficiency occurred because the facility did not have	

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F 880	Continued From page 22 protection, gloves, and a gown. Environmental Infection Control: Ensure that environmental cleaning and disinfection procedures are followed consistently and correctly; routine cleaning and disinfection procedures (e.g. using cleaners and water to pre-clean surfaces prior to applying an EPA-registered, hospital-grade disinfectant to frequently touched surfaces or objects for appropriate contact times as indicated on the product's label) are appropriate for SARS-CoV-2 in healthcare settings, including those patient-care areas in which aerosol-generating procedures are performed." According to the U.S. CDC guidelines Hand Hygiene Recommendations, Guidance for Healthcare Providers for Hand Hygiene and COVID-19, page last reviewed 1/8/2021 included, "Hands should be washed with soap and water for at least 20 seconds when visibly soiled, before eating, and after using the restroom. Immediately after glove removal." It further specified the procedure for hand hygiene which included, "When cleaning your hands with soap and water, wet your hands first with water, apply the amount of product recommended by the manufacturer to your hands, and rub your hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. Rinse your hands with water and use disposable towels to dry. Use a towel to turn off the faucet. Other entities have recommended that cleaning your hands with soap and water should take around 20 seconds. Either time is acceptable. The focus should be on cleaning your hands at the right times." 1. On 4/13/21 at 9:17 AM, the Executive Order 26, 4.b.	F 880	consistent audit on how staff are following COVID-19 protocols during testing, observation of PPE adherence and direct observation of hand hygiene protocols in the resident care areas. A Performance Improvement Project (PIP) is implemented to re-educate all staff on COVID-19 testing, PPE adherence and hand hygiene protocols. An audit is conducted as part of the facility PIP to ensure compliance. Monthly QAPI meetings will be conducted to monitor adherence. Directed Inservice Training/s were completed on May 19, 2021 on the following topics: Module 1 - Infection Prevention and Control Program https://www.train.org/main/course/1081350/ were completed by Topline staff (Department Heads) and Infection Preventionist CDC COVID-19 Prevention Messages for Frontline Long-Term Care Staff: Keep COVID-19 Out were viewed by all staff - (YouTube Video) CDC COVID-19 Prevention Messages for Frontline Long-Term Care Staff: Use PPE Correctly Out were viewed by all frontline staff - (YouTube Video) Nursing Home Infection Preventionist Training Course https://www.train.org/main/course/1081806/	

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F 880	Continued From page 23 Coordinator/Registered Nurse (MDSC/RN) performed a COVID-19 rapid test of the surveyor without disinfecting the table she used before and after testing. The surveyor observed the MDSC/RN wore a surgical mask and goggles. The MDSC/RN did not wear an isolation gown and an N95 mask during the testing. On 4/15/21 at 8:30 AM, the surveyor observed two used COVID-19 rapid testing kits on top of the table that was being used for testing visitors. There was a box of gloves, a box of COVID-19 testing kits, a container of disinfectant, a plastic bag of clean isolation gowns, folders, and a pen on the top of the same table. On that same date and time, the surveyor observed the MDSC/RN put aside the used testing kits near the plastic bag of clean isolation gowns. The MDSC/RN did not dispose of the used testing kits. The MDSC/RN did not disinfect the table before and after COVID-19 testing of the surveyor. The MDSC/RN did not wear an isolation gown during testing. On 4/15/21 at 8:45 AM, The MDSC/RN stated, "I should use a gown when doing testing." She further stated that the two used testing kits should have been disposed of immediately in the covered garbage bin. On that same date at 9:40 AM, the MDSC/RN stated "I haven't done that" disinfecting the table used in testing visitors. The MDSC/RN was not sure if the disinfecting container on top of the testing table can be used for disinfecting the table after each use. She further stated that she should have worn full PPE (i.e.) an N95 mask, face shield, gloves, and an isolation gown during	F 880	Module 7 - Hand Hygiene was viewed by all staff including topline staff and Infection preventionist The Infection Preventionist will conduct infection control audits focusing on proper PPE usage and disposal, environmental disinfection, and handwashing daily (on random shifts) x 30 days, the weekly x 8 weeks, then then monthly x 4months. The DON and the Medical Director will review audit results monthly. Element #4 A Performance Improvement Project (PIP) focusing on compliance with infection prevention and control practices will be conducted monthly x 6 months by the Infection Prevention and Control Committee to ensure compliance and identify trends and opportunities for improvement. Results of the PIP will be presented to the QAA Committee during the Quarterly Meetings.	

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 04/23/2021

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F 880	Continued From page 24	F 880		

COVID-19 testing. She indicated that she was educated on the proper way of COVID-19 testing.

On 4/15/21 at 1:58 PM, the surveyors met with the Licensed Nursing Home Administrator (LNHA), Infection Preventionist Nurse (IPN), Director of Nursing (DON), and made aware of the above concerns. The DON informed the surveyors that she spoke to the MDSC/RN and acknowledged the above concerns. The DON stated that the MDSC/RN should have worn an N95 mask and an isolation gown during COVID-19 testing. She further stated that the MDSC/RN should have disinfected the table after use.

On 4/19/21 at 10:30 AM, the surveyor observed the Assistant Director of Nursing (ADON) perform a rapid test of staff with an isolation gown, goggles, gloves, and a surgical mask. The ADON did not wear an N95 mask during COVID-19 testing.

On 4/19/21 at 10:39 AM, the ADON informed the surveyors that the COVID-19 testing of staff was every Monday and Thursday. The ADON stated that a complete PPE i.e. gown, surgical mask, gloves, and eye protection should be worn by staff performing the testing.

On that same date and time, the ADON stated that "It's been like that" we use a surgical mask when performing the rapid test of staff and visitors. The ADON was unable to recall how long surgical masks were being used when testing for COVID-19.

On 4/19/21 at 1:33 PM, the surveyors met with the LNHA, the DON and were made aware of the

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F 880	Continued From page 25 above concerns. 2. On 4/13/21 at 11:50 AM, the ADON informed the surveyor that the Executive Order 26, 4.b. unit was the observation and considered as Executive Order 26, 4.b. Executive Order 26, 4.b. unit because residents were Executive Order 26, 4.b. Executive Order 26, 4.b. The ADON stated that staff must wear a complete PPE i.e. a gown, gloves, a surgical mask, or a KN95 mask, and an eye protector before entering the PUI room. He further stated that staff must remove their gown and gloves before exiting the PUI room and dispose of them in a covered garbage step bin. On 4/13/21 at 12:12 PM, the surveyor observed the Physical Therapist Assistant (PTA) remove his gown and gloves and dispose of them in a regular garbage bin without a cover inside a PUI room of Resident#312. The PUI room had Contact and Droplet Precaution signs and PPE hung outside the door. The PTA acknowledged that he disposed of his gown and gloves in the garbage bin without cover. On that same date and time, the PTA stated that the garbage bin "should have a cover." He further stated that there was no covered step bin inside the resident's room which was why he disposed of them in a regular garbage bin. On 4/13/21 at 12:14 PM, the surveyor informed the ADON of the above concern. The ADON stated that the PTA should have used the covered step garbage bin. The ADON then went into the PUI room and showed that the covered step garbage bin was hidden behind the television table near the window. The ADON stated that the	F 880		

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F 880	Continued From page 26 PPE disposal covered step garbage bin should be near the exit door. On 4/15/21 at 1:58 PM, the surveyors met with the LNHA, DON, IPN and made them aware of the above concerns. Both the DON and IPN stated that the PTA should have disposed of the used gown in a covered garbage bin and that the bin should be placed near the exit door. 3. On 4/13/21 at 12:02 PM, the surveyor observed the ADON in the [redacted] unit enter the room of Resident #314 with a gown, gloves, face shield, and a surgical mask. The ADON did not wear an N95 mask. There were Contact and Droplet Precaution signs and PPE hung outside a [redacted] room. On that same date and time, the surveyor observed the ADON exited the [redacted] room. The ADON stated, "I don't need to use an N95 mask inside the [redacted] room because according to CDC, a surgical mask was ok." The surveyor notified the IPN immediately about the above concerns. The IPN educated the ADON and provided him with an N95 mask. A review of the facility Infection Prevention and Control Program Policy that was provided by the IPN with a reviewed date of 11/2020 included "Staff shall use personal protective equipment (PPE) according to established facility policy governing the use of PPE." A review of the facility transmission-based Precautions Policy that was provided by the IPN with a reviewed date of 11/2020 revealed that Droplet Precautions did not specify the kind of	F 880		

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F 880	Continued From page 27 mask to wear. A review of the facility Standard Precautions Protocol Policy that was provided by the IPN with a reviewed date of 11/2020 included "Mask, Eye Protection (goggles, Face shield) during aerosol-generating procedures on residents with suspected or prevention infection transmitted by respiratory aerosols (e.g., SARS), wear a fit-tested N95 or higher respirator in addition to gloves, gown, and face/eye protection. Environmental Control: develop procedures for routine care, cleaning/disinfection of environmental surfaces, especially frequently touched surfaces in resident-care areas." On 4/20/21 at 12:57 PM, the surveyors met with the DON, and there was no additional information provided by the facility. 4. On 4/20/21 at 8:55 AM, the surveyor observed a Licensed Practical Nurse (LPN) during Medication Pass remove a Blood Pressure (BP) monitor from a bag, don a pair of gloves and proceeded to clean the BP monitor. The LPN was then observed removing the gloves and taking the resident's blood pressure without performing hand hygiene. The surveyor interviewed the LPN who stated that she should have performed hand hygiene before and after removing the gloves. On 4/20/21 at 1:30 PM, the surveyor met with the DON, and there was no additional information provided by the facility. A review of the facility's policy titled Hand Hygiene under 5. Additional Considerations, b. "The use of gloves does not replace hand washing. Wash	F 880		

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F 880	Continued From page 28 hands after removing gloves." NJAC 8:39-19.4 (a) (1) (n) (2)	F 880		

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)	6/16/2021 (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 F0658 Reg. # 483.21(b)(3)(i) LSC	Correction Completed 05/31/2021	ID Prefix F0686 Reg. # 483.25(b)(1)(i)(ii) LSC	Correction Completed 05/31/2021	ID Prefix F0880 Reg. # 483.80(a)(1)(2)(4)(e)(f) LSC	Correction Completed 06/11/2021
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	
4/23/2021	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO