

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  315290	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/02/2026
NAME OF PROVIDER OR SUPPLIER  Buckingham at Norwood, The		STREET ADDRESS, CITY, STATE, ZIP CODE  100 McClellan Street Norwood, NJ 07648	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Complaint #2790946Based on observation, interview and record review it was determined that the facility failed to accurately document and administer pharmaceuticals in accordance with physicians' orders for 4 residents (#14, 67, 108, 156) of 32 reviewed. Specifically, Resident #14 received late administration of insulin, Resident #67 received late administration of pain medications, Resident #108 had documentation discrepancies regarding the administration of antianxiety medication, and Resident #156 had documentation discrepancies regarding the administration of narcotic pain medication. The findings are as follows.1.On 3/26/26 at 10:37 am, the surveyor observed Resident #67 awake in bed. Two certified nursing assistants were assisting the resident with morning personal care. The resident appeared agitated. On 3/30/26 at 11:00 am and 3/31/26 at 10:34 am, the surveyor again observed the resident in bed. The resident was calm, conversant, and denied discomfort.</p> <p>On 3/26/26 at 10:40 am, the surveyor observed Licensed Practical Nurse Unit Manager #1 (LPN UM #1) administering medications ordered for 9 am. She stated she had a callout and was covering for medication administration.</p> <p>On 3/27/26 at 10:22 am, the surveyor observed LPN #2 administering 9 am medications. LPN #2 stated it is difficult to give out all the 9 am medications between the 2-hour window of 8 am to 10 am (the standard of nursing practice is a 2-hour window, 1 hour before and 1 hour after the plotted administration time).</p> <p>On 3/27/26 at 10:24 am, the surveyor observed Registered Nurse #1 (RN #1) administering 9 am medications. RN #1 stated it is difficult to complete 9 am medication pass in 2 hours.</p> <p>On 3/27/26 at 10:26 am, the surveyor interviewed LPN UM #1. She confirmed the 3/26 and 3/27 medication administration ran at least 1/2 hour late. She confirmed this has become routine to run over the acceptable time of administration. She stated the physician has not been made aware of the late administered medications.</p> <p>A review of Resident #67's electronic medical record revealed the following information.</p> <p>The admission Record included diagnoses of rheumatoid arthritis and osteoarthritis.</p> <p>The 1/2/26 quarterly Minimum Data Set (MDS) assessment tool indicated the resident was able to understand verbal content and able to express ideas and wants (Section B), however, the resident answered all questions incorrectly in the Brief Interview for Mental Status (Section C). Section J indicated the resident received scheduled pain medication during the 5-day look back period. The resident was able to complete the pain assessment interview which indicated the resident had not (continued on next page)</p>		

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  315290	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/02/2026
NAME OF PROVIDER OR SUPPLIER  Buckingham at Norwood, The		STREET ADDRESS, CITY, STATE, ZIP CODE  100 McClellan Street Norwood, NJ 07648	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>experienced pain in the previous 5 days.</p> <p>The Pain Care Plan, last reviewed by the facility on 1/2/26, indicated that the resident experienced pain related to arthritis and was able to request pain medication and verbalize the severity of the pain.</p> <p>The Order Summary Report listed the following physician's orders for routine pain management.</p> <p>Tizanidine HCl oral tablet 2 mg. with meals for pain (scheduled 8 am, 12 pm, 5 pm).</p> <p>Tylenol 325 mg. give 2 tablets with meals for pain (scheduled 8 am, 12 pm, 5 pm).</p> <p>Lidocaine External Patch 4% to left upper back topically once a day for pain management (scheduled 9 am).</p> <p>Lidocaine External Patch 4% to left knee topically once a day for pain management (scheduled 9 am).</p> <p>The February 2026 Medication Administration Audit Report (a report documenting medications administered outside of the acceptable 2-hour window) revealed numerous late administrations of routine pain medications. A summary of late pain medications during the month of February 2026 follows.</p> <p>Tizanidine was administered late 43 times, Tylenol was administered late 36 times, Lidoderm patch to the back was administered late 18 times, and Lidoderm patch to the left knee was administered late 17 times.</p> <p>The medications which were scheduled to be administered at the beginning of the morning shift (Tylenol and Tizandine at 8 am and Lidoderm patches at 9 am) were frequently documented by the nurse as having been administered after 2 pm.</p> <p>The surveyor reviewed the facility policy titled Pain Management and Assessment, dated 5/1/25. Step 6 reads The medication regimen is implemented as ordered. Results of the interventions are documented and communicated directly to the provider when appropriate. Ongoing communication between the prescriber and the staff is necessary for the optimal and judicious use of pain medications.</p> <p>The surveyor reviewed the facility policy titled Administering Medications, revised 4/2019. Step 4 reads Medications are administered in accordance with prescriber orders, including any required time frame. Step 7 reads Medications are administered within one (1) hour of their prescribed time, unless otherwise specified.</p> <p>On 3/31/26, the surveyor spoke with the Licensed Nursing Home Administrator, the Director of Nursing (DON), and the Chief Nursing Officer regarding the discrepancies between scheduled times and administration times of routine pain medications.</p> <p>On 4/1/26, the DON responded to the survey team stating that the interdisciplinary team met along with the resident's family member to address the times of administration of pain medications.</p> <p>2. On 3/27/26 at 12:55 PM, the surveyor, in the presence of LPN #3, began the inspection of the (continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  315290	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/02/2026
NAME OF PROVIDER OR SUPPLIER  Buckingham at Norwood, The		STREET ADDRESS, CITY, STATE, ZIP CODE  100 McClellan Street Norwood, NJ 07648	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>narcotic medications, which were stored in a separately locked, permanently affixed compartment of the medication cart (narcotic box), located on the west side of the second floor.</p> <p>A review of the Individual Patient's Controlled Substance Administration Record (IPCSAR; declining inventory sheet used to track removal of a controlled drug from inventory) for Resident #108's Alprazolam 0.5 milligram (mg) tablets (generic for Xanax) revealed the following documentation by the nurses:</p> <ul style="list-style-type: none"> <li>-On 3/17/26 at 9, a dose was signed removed.</li> <li>-On 3/18/26 at 9 PM, a dose was signed removed.</li> <li>-On 3/20/26 at 9 PM, a dose was signed removed.</li> <li>-On 3/21/26 at 9 PM, a dose was signed removed.</li> </ul> <p>A review of the March 2026 Medication Administration Record (MAR) for Resident #108 revealed the following:</p> <ul style="list-style-type: none"> <li>-On 3/17/26, no administration of Alprazolam was documented.</li> <li>-On 3/18/26 at 11:32 PM, the administration of Alprazolam was documented.</li> <li>-On 3/20/26, no administration of Alprazolam was documented.</li> <li>-On 3/21/26 at 10:51 PM, the administration of Alprazolam was documented.</li> <li>-On 3/22/26, the effectiveness of Alprazolam was not documented.</li> </ul> <p>A review of the Care Plan with a start date of 3/8/26 revealed Resident #108 uses antidepressant medication Xanax 0.5mg related to depression. Interventions included but were not limited to, Administer Antidepressant medications as ordered by physician. Monitor/Documented side effects and effectiveness Q-SHIFT.</p> <p>A review of the Order Summary Report for Resident #108 revealed the following orders:</p> <ul style="list-style-type: none"> <li>-Alprazolam Oral Tablet 0.5 mg Give 1 tablet my mouth every 24 hours as needed for anxiety for 14 days Xanax 0.5 mg 1 tablet by mouth nightly q 24H with a start date of 3/8/26.</li> <li>-Alprazolam Oral Tablet 0.5 mg Give 1 tablet by mouth one time only for anxiety until 3/22/26 23:59 with a start date of 3/22/26.</li> </ul> <p>On 3/27/26 at 1:30 PM, the surveyor discussed the concerns with the LNHA, DON, and [NAME] President (VP) of Clinical Services. The VP of Clinical Services stated the protocol is the nurse signs the declining inventory sheet when they remove the controlled medication from the bingo card. The nurse signs the MAR after they administer the controlled medication.</p> <p>On 3/31/2026 at 1:40 PM, the survey team met with the LNHA and the DON. The surveyor, in the presence of the survey team, interviewed the DON who stated that the expectation is to sign the (continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  315290	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/02/2026
NAME OF PROVIDER OR SUPPLIER  Buckingham at Norwood, The		STREET ADDRESS, CITY, STATE, ZIP CODE  100 McClellan Street Norwood, NJ 07648	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>declination sheet after popping the tablet out of the bingo card and to sign the MAR right away after administering the medication. The DON also acknowledged that the effectiveness of Alprazolam administered on 3/22/26 should have been documented on the MAR in accordance with Resident #108's Care Plan. The DON stated that the nurses admitted they did not act according to the standard of practice.</p> <p>A review of the facility's Administering Medications policy, revised 4/2019, revealed the following:</p> <ul style="list-style-type: none"> <li>-The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones.</li> <li>-As required or indicated for a medication, the individual administering the medication records in the resident's medical record: the date and time the medication was administered; the dosage; the route of administration; the injection site (if applicable); any complaints or symptoms for which the drug was administered; any results achieved and when those results were observed; and the signature and title of the person administering the drug.</li> </ul> <p>3. On 4/1/26 at 9:26 AM, the surveyor reviewed the electronic medical record (EMR) for Resident #156.</p> <p>The admission Record revealed Resident #156 had diagnoses that included but were not limited to, dementia, osteoarthritis (chronic degenerative joint disease in which the tissues in the joint break down over time), and left knee pain.</p> <p>A Comprehensive MDS assessment dated [DATE], indicated the facility assessed the resident's cognition using a Brief Interview Mental Status (BIMS) test. Resident #156 scored 0 out of 15, which indicated the resident had severe cognitive impairment. The resident was also coded as receiving a scheduled pain management regimen.</p> <p>A physician's order dated 10/5/24 indicated to give Tramadol 50 mg tablet, one tablet by mouth one time a day for knee pain. The medication was scheduled to be administered at 9 AM.</p> <p>A physician's order dated 12/19/25 indicated to give Tramadol 50 mg tablet, half a tablet (equaling 25 mg) by mouth two times a day for moderate to severe pain. The medication was scheduled to be administered at 2 PM and 10 PM.</p> <p>A review of the March 2026 Medication Administration Record (MAR) revealed for the above Tramadol 25 mg order there were two entries left blank and unsigned on 3/21/26 for the 2 PM dose and 3/26/26 for the 10 PM dose.</p> <p>On 4/1/26 at 10:58 AM, the surveyor asked LPN #5, who was assigned to care for Resident #156, to review the resident's Controlled Substance Administration Record (CSAR; an accountability log, used to track the chain of custody, usage, and disposal of controlled substances). The CSAR was completed by the nurses who wrote the date, the time, and their signature when a medication dose was removed for administration. The CSARs currently in use were in a binder on the medication cart.</p> <p>The surveyor with LPN #5 reviewed the Tramadol 50 mg tablet CSAR which had entries dated from 3/25/26 to 4/1/26 and revealed the following: (continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  315290	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/02/2026
NAME OF PROVIDER OR SUPPLIER  Buckingham at Norwood, The		STREET ADDRESS, CITY, STATE, ZIP CODE  100 McClellan Street Norwood, NJ 07648	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>There were two entries on 3/25/26, one signed for 9 AM and another signed at 9 PM.</p> <p>There were two entries on 3/26/26, one signed for 9 AM and another signed at 9 PM. LPN #5 confirmed the signature at 9 AM was their signature and was not sure which nurse signed at 9 PM.</p> <p>LPN #5 stated Resident #156 received Tramadol 50 mg at 9 AM and Tramadol 25 mg at 2 PM and 10 PM as ordered by the physician. The LPN could not speak to why there were entries for 9PM on the Tramadol 50 mg CSAR.</p> <p>The surveyor with LPN #5 reviewed the Tramadol 50 mg, half tablet (Tramadol 25 mg) CSAR with entries dated 3/10/26 to 3/26/26 stored in Resident #156's hard copy chart which revealed the following:</p> <p>On 3/21/26 at 2 PM, LPN #5 confirmed that was their signature which indicated Tramadol 25 mg was removed for administration to Resident #156.</p> <p>On 3/25/26 and 3/26/26 there was no entry for 10 PM that the medication was dispensed for administration.</p> <p>The surveyor discussed with LPN #5 that review of the March 2026 MAR revealed unsigned entries on 3/21/26 at 2 PM and 3/26/26 at 10 PM. LPN #5 reviewed the MAR for 3/21/26 on the EMR, confirmed they had worked on the 7AM-3PM shift, and that the entry was unsigned. The LPN did not know why the entry was left unsigned and acknowledged it should have been signed for the medication's administration.</p> <p>The surveyor and LPN #5 were joined by the Registered Nurse Unit Manager (RN/UM) who was informed of the missing signatures on the MAR for Tramadol 25 mg and the concerns found upon the CSAR review for Tramadol. The RN/UM and the surveyor reviewed the above Tramadol 50 mg and Tramadol 25 mg CSAR forms which indicated the nurses on 3/25/26, 3/26/26, and 3/30/26 at 10 PM signed for Tramadol 50 mg being dispensed as administered instead of Tramadol 25 mg. The RN/UM stated an investigation would be initiated to determine what happened.</p> <p>On 4/1/26 at 11:15 AM the surveyor informed the Director of Nursing (DON) regarding the above concerns. The DON replied that the RN/UM had just informed her, and she was on her way to the unit to investigate. The DON acknowledged if the Tramadol 50 mg dose was scored (an indented line on a medication pill designed to allow it to be safely and easily split into smaller, equal doses) and the nurse cut the pill to provide a Tramadol 25 mg dose it would be expected for there to be two nurse signatures for the entry on the CSAR to indicate a witness for the disposal of one half of the cut tablet. None of the entries identified documented disposal or a second nurse as a witness.</p> <p>On 4/1/26 at 1:17 PM, the surveyor informed the DON, the LNHA, and the CNO of the above concerns for the missing signed entries on the MAR; and the discrepancies identified of the nurses dispensing Tramadol 50 mg for administration instead of Tramadol 25 mg. The DON stated an investigation was initiated. The surveyor requested copies of the Tramadol CSARs for February 2026 and March 2026.</p> <p>Additional review and summary of discrepancies identified for Tramadol CSARs in February 2026 and March 2026 revealed:</p> <p>On 2/5/26 for the Tramadol 25 mg 10 PM dose, the nurse signed as dispensed Tramadol 50 mg and (continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  315290	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/02/2026
NAME OF PROVIDER OR SUPPLIER  Buckingham at Norwood, The		STREET ADDRESS, CITY, STATE, ZIP CODE  100 McClellan Street Norwood, NJ 07648	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>not Tramadol 25 mg. The surveyor reviewed the February 2026 MAR which revealed the Tramadol 25 mg medication dose entry at 10 PM was signed as administered.</p> <p>On 2/12/26 for the Tramadol 25 mg 10 PM dose, the nurse signed as dispensed Tramadol 50 mg and not Tramadol 25 mg. The surveyor reviewed the February 2026 MAR which revealed the Tramadol 25 mg medication dose entry at 10 PM was signed as administered.</p> <p>On 2/19/26 for the Tramadol 25 mg 10 PM dose, the nurse signed as dispensed Tramadol 50 mg and not Tramadol 25 mg. The surveyor reviewed the February 2026 MAR which revealed the Tramadol 25 mg medication dose entry at 10 PM was signed as administered.</p> <p>On 2/23/26 for the Tramadol 25 mg 10 PM dose, the nurse signed as dispensed Tramadol 50 mg and not Tramadol 25 mg. The surveyor reviewed the February 2026 MAR which revealed the Tramadol 25 mg medication dose entry at 10 PM was signed as administered.</p> <p>On 2/26/26 for the Tramadol 25 mg 10 PM dose, the nurse signed as dispensed Tramadol 50 mg and not Tramadol 25 mg. The surveyor reviewed the February 2026 MAR which revealed the Tramadol 25 mg medication dose entry at 10 PM was signed as administered.</p> <p>On 3/13/26 for the Tramadol 25 mg 10 PM dose, the nurse signed as dispensed Tramadol 50 mg and not Tramadol 25 mg. The surveyor reviewed the March 2026 MAR which revealed the Tramadol 25 mg medication dose entry at 10 PM was signed as administered.</p> <p>On 3/25/26 for the Tramadol 25 mg 10 PM dose, the nurse signed as dispensed Tramadol 50 mg and not Tramadol 25 mg. The surveyor reviewed the March 2026 MAR which revealed the Tramadol 25 mg medication dose entry at 10 PM was signed as administered.</p> <p>On 3/26/26 for the Tramadol 25 mg 10 PM dose, the nurse signed as dispensed Tramadol 50 mg and not Tramadol 25 mg. The surveyor reviewed the March 2026 MAR which revealed the Tramadol 25 mg medication dose entry at 10 PM was signed as administered.</p> <p>On 3/30/26 for the Tramadol 25 mg 10 PM dose, the nurse signed as dispensed Tramadol 50 mg and not Tramadol 25 mg. The surveyor reviewed the March 2026 MAR which revealed the Tramadol 25 mg medication dose entry at 10 PM was signed as administered.</p> <p>On 4/2/26 at 10:12 AM, the LNHA, the DON, and the CNO met with the survey team. The DON stated Resident #156's CSARs for Tramadol were reviewed and acknowledged the concern found as the records reflected that Tramadol 50 mg was administered instead of Tramadol 25 mg. The DON stated the physician and the resident's representative were notified of the occurrences; there were no signs or symptoms of adverse effect to the resident; no negative clinical impact noted; and nursing staff education was initiated regarding documentation and medication handling errors. There was no additional information provided by the facility's management.</p> <p>A review of the undated, facility provided policy titled, Administering Medications, under Policy Interpretation and Implementation revealed: .</p> <p>4. Medications are administered in accordance with prescriber orders.</p> <p>10. The individual administering the medication checks the label THREE (3) times to verify the right (continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  315290	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/02/2026
NAME OF PROVIDER OR SUPPLIER  Buckingham at Norwood, The		STREET ADDRESS, CITY, STATE, ZIP CODE  100 McClellan Street Norwood, NJ 07648	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>resident, right medication, right dosage, right time and right method (route) of administration before giving the medication.</p> <p>A review of the undated, facility provided policy titled, Documentation of Medication Administration, under Policy Interpretation and Implementation revealed:</p> <p>A nurse documents all medications administered to each resident on the resident's MAR.</p> <p>Administration of medication is documented immediately at least within the hour after it is given.</p> <p>4.) On 3/26/26 at 11:15 AM, the surveyor observed Resident #14 in a wheelchair in the nursing unit dining room awake and alert. The resident was participating in an activity with staff in attendance. The resident responded to greeting from surveyor with the assistance of the facility's interpreter.</p> <p>A review of Resident #14's admission record reflected the resident was admitted to the facility with diagnoses including but not limited to type 2 diabetes, dementia and chronic kidney disease.</p> <p>A review of Resident #14's annual Minimum Data Set (MDS), an assessment tool dated 12/24/25, reflected that the resident was severely cognitively impaired.</p> <p>A review of Resident #14's Physicians orders (POs) reflected physician's orders for 2 types of insulin in 3 orders. PO #1 dated 7/18/25: Insulin Aspart Injection solution 100 unit/milliliter. Inject per sliding scale: if blood glucose is 0-150 = 0 units, if 151-200 = 2 units, if 201-250 = 4 units, if 251-300 = 6 units, if 301-350 = 8 units, if 351-400 = 10 units, if above 400 give 10 units and notify the provider, Give subcutaneously three times a day (8:00AM, 11:30 AM and 4:30PM). PO #2 dated 9/23/25: Insulin Glargine Inject 8 units subcutaneously in the morning (9:00 am), discontinued on 3/26/26. PO #3 dated 3/26/26: Insulin Glargine Inject 4units subcutaneously in the morning (9:00 am).</p> <p>A review of Resident#14's medication administration record (MAR) and the Medication audit summary report for February and March of 2026 reflected that aspart insulin, PO #1 was administered more than one hour after the ordered administration time on 54 of the ordered 93 occurrences in March 2026. The MAR reflected that insulin glargine, PO #2 dated 9/23/25 was administered more than 1 hour after the ordered administration time on 16 of 31of the ordered occurrences in March 2026. The MAR reflected insulin glargine PO #3 dated 3/26/26 was administered more than 1 hour after the ordered administration time on 3 of 5 ordered occurrences.</p> <p>On 4/1/26 at 11:45 AM, the surveyor interviewed LPN #3 concerning Resident #14's insulin orders and administration, The LPN confirmed she administered the residents aspart insulin ordered for 4/1/26 at 8:00 AM and the administration time of 9:17 AM was accurate in the (EHR). The LPN acknowledged medication should have been administered between 1 hour prior to and 1 hour after ordered administration time. The surveyor asked the LPN about procedure for administering medications late and the LPN explained she should have notified the provider and obtained an order for administering the medication at the later time.</p> <p>On 4/1/26 at 1:28 PM, The Survey team met with the Director of Nursing (DON) and the Licensed Nursing Home Administrator and the Chief Nursing Officer. The DON acknowledged that all nurses should have administered the ordered Insulin within an hour of the ordered administration time.</p> <p>NJAC 8:39-29.1; 29.2; 29.5; 29.7</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  315290	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/02/2026
NAME OF PROVIDER OR SUPPLIER  Buckingham at Norwood, The		STREET ADDRESS, CITY, STATE, ZIP CODE  100 McClellan Street Norwood, NJ 07648	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>Based on observation, interview, and record review it was determined that the facility failed to ensure call devices were positioned within reach of a resident who was at risk for falls. The deficient practice was cited for 1 resident (Resident #59) and evidenced by the following. On 3/26/26 at 11:30 am, the surveyor observed Resident #59 standing in the doorway of their room next to their bed. The resident told the surveyor that they needed help because there was spilled water in the room. The surveyor inquired whether the resident pushed the call device to summon help. The resident replied she did not know where the device was. The call device was observed on the floor under the bed near the roommate's bed. On 3/27/2026 at 10:37 am, the surveyor observed the resident lying on their bed. The surveyor observed the call device under the bed near the roommate's bed. When asked by the surveyor where the call bell was, the resident replied they did not know. On 3/30/26 at 9:50 am, the surveyor observed the resident lying on their bed. The surveyor observed the call device on the floor under the bed near the roommate's bed. The resident indicated they did not know where the call device was and stated it's important that I have it in case I need to use it. On 3/30/26 at 10 am, the surveyor spoke with the Licensed Practical Nurse Unit Manager explaining the call bell was on the floor under the bed on 3/26, 3/27, and 3/30. She stated it should have been clipped to the bed where the resident could reach it. She stated staff is to make rounds to be sure call bells are accessible to residents. A review of the resident's medical record revealed the following information. The admission Record included diagnoses of altered mental status, difficulty in walking, and dementia. The Care Plan Report included a 6/9/24 fall risk care plan related to confusion and antidepressant use. Fall prevention interventions included providing a working and reachable call device. The 12/26/25 quarterly Minimum Data Set assessment tool indicated the resident was severely cognitively impaired. The facility's policy titled Answering the Call Light, revised September 2022, noted in general guideline #5 Ensure that the call light is accessible to the resident when in bed. On 3/30/2026 at 1:18 pm, the surveyor spoke with the Licensed Nursing Home Administrator, the Director of Nursing (DON), and the Chief Nursing Officer regarding the concern of the call placement for 3 days of the survey. NJAC 8:39-27.1(a)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  315290	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/02/2026
NAME OF PROVIDER OR SUPPLIER  Buckingham at Norwood, The		STREET ADDRESS, CITY, STATE, ZIP CODE  100 McClellan Street Norwood, NJ 07648	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, interviews, record review and review of other pertinent facility provided documentation, the facility failed to continue to assess a resident after a fall to ensure the resident had no adverse effects from the event in 1 of 3 residents reviewed for falls (Resident #80). This deficient practice was evidenced by the following: On 3/26/26 at 10:52 AM, the surveyor observed Resident # 80 in room seated in chair, interviewable, and stated that they are pleased with the care. A review of the Resident # 80's electronic health record (EHR) reflects the resident was admitted with diagnoses that included but were not limited to a fracture of the right femur, dementia, difficulty walking and unsteadiness on feet. A review of Resident #80's annual Minimum Data Set (MDS), dated [DATE], an assessment tool, reflected that the resident is moderately cognitively impaired. The MDS reflected that the resident used a wheelchair for mobility and needed assistance with transfers. A review of the progress notes for Resident #80 reflected the resident was discovered to have sustained an unwitnessed fall on 12/31/25 at 3:30 PM. The nursing progress note dated 12/30/25 at 3:32 PM reflected the resident was found on the bathroom floor of room [ROOM NUMBER] and assessed with blood on the resident's face and on the floor. The note also documented the resident was unable to provide details as to what had occurred. A nursing note on 12/30/25 at 4:13 PM, reflected the Assistant Director of Nursing acknowledging receipt of a report of Resident #80's fall. A nursing progress note dated 12/30/25 at 10:14 PM documented a post fall assessment of resident performed by the Registered Nurse assigned to Resident 80's care on 12/30/25 for the 3 PM to 11 PM shift. The review of the EHR did not reveal any further documentation of follow up assessments on Resident #80's 12/30/25 unwitnessed fall. On 3/27/26 at 1:30 PM, the surveyor interviewed the Director of Nursing (DON). The DON provided the facility's fall prevention program policy dated 5/1/25 and confirmed the policy required nurses to chart on a resident that suffered an unwitnessed fall be assessed by the nurse assigned to the resident every shift for 72 hours post fall. The DON further confirmed this documentation should include neurological checks and an assessment of the resident's status. The DON confirmed no nursing post fall resident assessments were documented after 12/30/25 at 10:14 PM and nursing assessments were required to be documented every shift until 1/2/26 at 3:30 PM. A review of the facilities policy titled Fall Prevention Program, dated 5/1/25 reflected after a resident had sustained a fall. Each nurse, each shift will observe the resident and document for 72 hours in the resident's medical record. N.J.A.C. 8:39-27.1 (a)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  315290	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/02/2026
NAME OF PROVIDER OR SUPPLIER  Buckingham at Norwood, The		STREET ADDRESS, CITY, STATE, ZIP CODE  100 McClellan Street Norwood, NJ 07648	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>Based on observation, interview and review of pertinent facility documentation, it was determined that the facility failed to monitor the nutritional status for 1 of 1 residents reviewed for nutritional status (Resident #137), by not following a physician's orders for monitoring of the resident's weight. The deficient practice was evidenced by the following: On 3/26/26 at 10:46 AM, the surveyor observed resident in bed, awake and responsive with the call bell placed within the resident's reach. A review of Resident #137's admission Record reflected that the resident was admitted to the facility with diagnoses which included but were not limited to; type 2 diabetes, obesity, essential hypertension (high blood pressure) and urinary retention. A review of Resident #137's annual Minimum Data Set (MDS), an assessment tool dated 2/20/26, reflected that the resident was moderately cognitively impaired. A review of the resident's Physician Order Summary report reflected the following physician's order (PO): Weigh resident daily and notify provider if resident gains more than 3 lbs. in 24 hour period or greater than 5 lbs. in one week, initiated on 11/11/25. A review of Resident #137's medical record does not indicate a weight was obtained on 50 of 59 days in the Months of February and March of 2025 as required by the PO. A review of electronic health records (EHR) reflects the following weights were obtained and documented: 2/5/26 235.4 lbs., 2/8/26 235.4 lbs., 2/14/26 235.2 lbs., 2/15/26 235.3 lbs., 2/17/26 235.3 lbs., 2/18/26 235.3 lbs., 2/28/26 235.5 lbs., 3/8/26 230 lbs., 3/29/26 234.5 lbs. A review of the resident's EHR does not reflect documentation that the recorded weights were discussed with the provider during the months of March or April 2026. On 4/1/26 at 11:00 AM, the surveyor interviewed Resident #137 with assistance of the facility's interpreter. The resident demonstrate he was poor historian on his health status. The resident could not recall being weighed by staff and did not verbalize a reason that the physician may have ordered a daily weight. On 04/1/2026 at 11:35 AM, the survey interviewed the Registered Nurse (RN) assigned to Resident #37s care. The RN confirmed a physician's order was present in the resident's EHR to obtain the resident's weight daily. The RN confirmed nurses are required to documents weights in the vital signs section of the resident's EHR and sign the Medication Administration Record (MAR) that they were obtained. The RN acknowledged that residents should always have weights assessed and documented according to the physician's orders. A review of the facility policy, Weight Assessment and Documentation, reflected . residents are weighed at admission and at intervals established by the interdisciplinary team. weights are recorded in the weight record chart in the individual's medical record. On 4/1/26 at 1:30 PM, the survey team met with Licensed Nursing Home Administrator and the Director of Nursing (DON) to discuss the above observations and concerns. The DON confirmed that the weights were not obtained and documented per the PO for Resident #137 on 50 of 59 days in March and April 2026. NJAC 8:39-17.1(c); 17.2(d); 27.2(e), (k)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  315290	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/02/2026
NAME OF PROVIDER OR SUPPLIER  Buckingham at Norwood, The		STREET ADDRESS, CITY, STATE, ZIP CODE  100 McClellan Street Norwood, NJ 07648	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>Based on observation, interview, and record review, it was determined that the facility failed to clarify oxygen therapy orders to ensure a resident was provided with care, consistent with professional standards of practice, for 1 of 1 resident (Resident #16) reviewed for respiratory care. The deficient practice was evidenced by the following: On 3/26/26 at 11:11 AM, the surveyor observed Resident #16 sitting in a wheelchair, alert and sitting with other residents at a table for a recreational activity. The resident was not on any oxygen therapy and there were no observed concerns. On 4/1/26 at 9:09 AM, the surveyor reviewed the Electronic Medical Record (EMR) of Resident #16. The admission Record (a summary of important resident information) revealed Resident #16 had diagnoses that included but were not limited to, hemiplegia (a paralysis or severe weakness affecting one side of the body), and dementia. A Quarterly Minimum Data Set assessment, a tool used to facilitate management of care, dated 1/26/26, indicated the facility assessed the resident's cognition using a Brief Interview Mental Status (BIMS) test. Resident #16 scored 5 out of 15, which indicated the resident had severe cognitive impairment. A physician's order dated 10/13/25 indicated to administer oxygen at 2-6 liters per minute (LPM) via nasal cannula as needed (PRN) for shortness of breath. A physician's order dated 10/13/25 indicated the resident was receiving hospice care services. A review of the March and April 2026 Treatment Administration Record (TAR) for the above oxygen order entry revealed the resident had not needed PRN oxygen therapy. On 4/1/26 at 10:50 AM, the surveyor interviewed the Registered Nurse Unit Manager (RN/UM) who stated oxygen therapy orders should have a specified LPM. The RN/UM further explained if the oxygen therapy ordered was not helping a resident, the physician could be called to obtain an order to increase the LPM of oxygen administered. The surveyor discussed with the RN/UM the concern for Resident #16's PRN oxygen order which indicated oxygen delivery at 2-6 LPM. The RN/UM stated there may be oxygen therapy recommendations for a range of LPM, especially for hospice care residents. The RN/UM acknowledged the nurses should clarify with the physician the oxygen therapy order as it should specify an LPM. The RN/UM stated she would review and clarify Resident #16's order with the physician. On 4/1/26 at 1:17 PM, the surveyor informed the Director of Nursing (DON), the Licensed Nursing Home Administrator, and the Chief Nursing Officer about the concern with Resident #16's PRN oxygen therapy order. The DON stated the expectation was for an oxygen therapy order to have a specific LPM and not a range to administer. The DON further explained that the RN/UM clarified the order with the physician after surveyor inquiry. There was no additional information provided by the facility's management. A review of the facility provided policy with the subject of Respiratory Care Policy revealed under Policy: .The facility shall provide safe, effective, and individualized respiratory care services to all residents in accordance with physician orders, a professional standards of practice, and regulatory requirements. NJAC 8:39-27.1(a)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  315290	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/02/2026
NAME OF PROVIDER OR SUPPLIER  Buckingham at Norwood, The		STREET ADDRESS, CITY, STATE, ZIP CODE  100 McClellan Street Norwood, NJ 07648	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0836</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and review of pertinent facility documents it was determined that the facility failed to notify CMS (Centers for Medicare &amp; Medicaid Services) and receive authorization for a change in facility name in accordance with 42 CFR (Code of Federal Regulations) 424.516. This deficient practice was evidenced by the following: According to 42 CFR 424.516 Additional provider and supplier requirements for enrolling and maintaining active enrollment status in the Medicare Program: (a) Certifying compliance. CMS enrolls and maintains an active enrollment status for a provider or supplier when that provider or supplier certifies that it meets, and continues to meet, and CMS verifies that it meets, and continues to meet, all of the following requirements: (1) Compliance with title XVIII of the Act and applicable Medicare regulations. (2) Compliance with Federal and State licensure, certification, and regulatory requirements, as required, based on the type of services or supplies the provider or supplier type will furnish and bill Medicare. (3) Not employing or contracting with individuals or entities that meet either of the following conditions: (i) Excluded from participation in any Federal health care programs, for the provision of items and services covered under the programs, in violation of section 1128 A(a)(6) of the Act. (ii) Debarred by the General Services Administration (GSA) from any other Executive Branch procurement or nonprocurement programs or activities, in accordance with the Federal Acquisition and Streamlining Act of 1994, and with the HHS Common Rule at 45 CFR part 76 (d) Reporting requirements for physicians, nonphysician practitioners, and physician and nonphysician practitioner organizations. Physicians, nonphysician practitioners, and physician and nonphysician practitioner organizations must report the following reportable events to their Medicare contractor within the specified timeframes: (1) Within 30 days - (i) A change of ownership; (ii) Any adverse legal action; or (iii) A change in practice location. (2) All other changes in enrollment must be reported within 90 days. On 3/26/26 at 8:55 AM, upon arrival to the facility, the surveyor observed a sign outside the facility which revealed Excelcare at [NAME], not [NAME] at [NAME]. On 3/26/26 at 10:30 AM, the Licensed Nursing Home Administrator (LNHA) stated that the facility was now owned by Excelcare and that they sent in a request for name change to the state but they did not do the name change through CMS yet. The LNHA stated that he did not have a business card to provide the surveyor, yet, the Director of Nursing (DON) provided the surveyor with a business card. The DON's business card revealed that the facility name on the card was listed as Excelcare at [NAME]. The LNHA provided the surveyor with the Facility Assessment which revealed Excelcare at [NAME] documented on the cover page, and the Facility Assessment, which also revealed Excelcare at [NAME] documented on the cover page. On 3/27/26 at 10:40 AM, the LNHA provided the surveyor with a letter dated February 28, 2025 which revealed that the facility had sent written notification to the Assistant Commissioner to indicate the agreement for new management. The surveyor met with the facility LNHA and Director of Nursing (DON), to discuss the deficient practice of utilizing the facility name ExcelCare at [NAME] without CMS approval. No further information or documentation was provided to the survey team to refute these findings. NJAC 8:39-5.1 (a)</p>		