STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315290	A. BUILDING **01** B. WING _____	**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
E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 04/13/21 . The Buckingham at Norwood was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. The Buckingham at Norwood is a 3 story building that was built in 80's. It is composed of Type II construction. The facility is divided into multiple smoke zones.	K 000		
K 222 SS=D	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the	K 222		5/7/21

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

Electronically Signed | 05/07/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315290	A. BUILDING **01** B. WING _____	**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
K 222	Continued From page 1 rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS	K 222		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315290	A. BUILDING **01** B. WING _____	**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
K 222	Continued From page 2 Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review on 4/13/21, it was determined that the facility failed to comply with the exit door special locking requirements of NFPA 101:2012 - 7.2.1.6.1 as evidenced by the following: During a tour of the [redacted] Unit in the presence of the facility's Maintenance Director at 1:00 PM, the surveyor observed one of two exit doors locked with a delayed-egress lock that failed to open when tested. The exit door at the end of the corridor by resident room#18 did not open within 15-30 seconds when the release mechanism (push-bar) was engaged by applying continuous pressure. Also, the delayed-egress lock was equipped with a coded keypad. The lock failed to release when the code was inputted by the Maintenance Director. This finding was verified by the Maintenance Director in an interview during the observation. Also, the Maintenance Director stated in an interview at 2:27 PM that the delayed-egress lock failure to release was caused by a faulty connection to a patient wanderguard system and that the issue was resolved. A review of the facility's preventive maintenance records at 2:30 PM indicated that exit doors/locks	K 222	HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED: The Egress door at the end of the [redacted] hallway failed to release after delayed egress test. POC : On 4/13/21 the faulty wire connection between the wander guard and the door was repaired by the maintenance director. MONITORING The Maintenance Director or designee will round daily and check the wander guard system and the egress doors in the facility. The Rounds will be tracked by maintenance and reported to the maintenance Director and QAPI committee Quarterly X 1 YR.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315290	A. BUILDING **01** B. WING _____	**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
K 222	Continued From page 3 were routinely checked and was last done on 04/01/21. The surveyor verbally informed the facility's Administrator of this finding during the Life Safety Code exit conference a 2:45 PM NJAC-8:39-31.2(e) NFPA 101:2012 7.2.1.6.1	K 222		
K 781 SS=D	Portable Space Heaters CFR(s): NFPA 101 Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 4/13/21, it was determined that the facility failed to prohibit the use of portable space heaters in resident sleeping areas. This deficient practice was is evidenced by the following finding: At 12:15 PM the surveyor observed, in the presence of the facility's Maintenance Director, a portable heater in the Social Services office located on the [redacted] floor nurses unit. The heater was not on at the time of surveyor's observation. This finding was verified by the Maintenance Director in an interview during the observation who immediately removed both items.	K 781	HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED: A PORTABLE Space heater was found in social services on [redacted] floor. POC : on 4/13/21 Space heater was removed immediately from the office. On 5/3/21 Education was provided to all department heads and staff members regarding the NO USAGE of space heaters at anytime in the building by maintenance Director. HOW FACILITY WILL MONITOR	5/25/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315290	A. BUILDING **01** B. WING _____	**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
K 781	Continued From page 4 The surveyor verbally informed the facility's Administrator of this finding during the Life Safety Code exit conference at 2:45 PM. NJAC 8:39-31.2(e) NFPA 101:2012 - 19.7.8	K 781	All space heaters were removed from the building by the maintenance director on 4/14/21. The maintenance Director Or Designee will round weekly to identify that there are no space heaters in the facility. This will be done by the maintenance director or designee and results reported to the Administrator and QAPI committee X4 Quarters. Maintenance Director or Designee will report to the Quarterly QAPI Committee X 4 Quarters.	
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4.	K 920		5/7/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315290	A. BUILDING **01** B. WING _____	**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
K 920	Continued From page 5 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 4/13/21, it was determined that the facility failed to prohibit the use of electrical UL rated power strips in the patient care vicinity: This deficient practice was is evidenced by the following finding: At 12:15 PM the surveyor observed, in the presence of the facility's Maintenance Director, a unprotected electrical power strip plugged into a standard wall outlet. This device was not UL 1363 rated and was used as an electrical extension to power a portable heater in the Social Services office located on the 2nd floor nurses unit. This finding was verified by the Maintenance Director in an interview during the observation and who immediately removed both items. The surveyor verbally informed the facility's Administrator of this finding during the Life Safety Code exit conference at 2:45 PM. NJAC 8:39-31.2(e) NFPA 101:2012 - 19.7.8	K 920	HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED A NON-UL listed power cord found in 2nd fl social services office. on 4/13/21 The power cord was removed by the maintenance Director On 4/13/21 in-service was presented to all staff regarding non usage of extension cords except 1363 UL which is allowed to be used in the facility. HOW WILL MONITOR WEEKLY rounds will be conducted by the maintenance team or designee and will be reported to QAPI Committee for next 2 Quarters.	
K 923 SS=D	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet	K 923		5/19/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315290	A. BUILDING **01** B. WING _____	**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
K 923	Continued From page 6 Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to comply with the oxygen tank storage requirements of NFPA 99 as evidenced by the following: Oxygen tanks exceeding 300 cubic feet in volume (12 e-tanks) were stored within 5-feet of	K 923	HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED Oxygen tanks exceeding 300 cubic feet were stored within 5 feet of combustible items.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315290	A. BUILDING **01** B. WING _____	**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
K 923	Continued From page 7 combustible items. At 12:00 PM the surveyor observed, in the presence of the facility's Maintenance Director, 25 oxygen cylinders (e-tanks) stored within 4-feet of combustible items in a multi-supply storage room located in the basement of the building. The combustible items were assorted patient care supplies stored in three cardboard boxes and two bed mattresses. The total volume of oxygen stored in this room was 625 cubic feet in volume, exceeding the maximum allowed by 325 cubic feet in volume (12 e-tanks). Also, one of the e-tanks was unsecured and laying horizontally on top of the other 24 e-tanks which were properly secured. This finding was verified by the facility's Maintenance Director in an interview during the observation. The surveyor verbally informed the facility's Administrator of this finding during the Life Safety Code survey exit at 2:45 PM. NJAC 8:39-31.2(e) NFPA 99	K 923	4/13/21 Oxygen tanks were moved to a different area more than 5 feet from any combustible items and secured on 4/13/21. on 4/13/31 the maintenance team was In-serviced on how to properly store and secure oxygen tanks. HOW WILL MONITOR 1. The Maintenance Director will conduct weekly random audits of oxygen storage areas and make sure that tanks are stored safely and secured in place.. 2. Findings will be submitted to the quarterly QAPI committee and the administrator Quarterly X 1 year.	