STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315209	A. BUILDING **01** B. WING _____	**08/21/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMMONTON CENTER FOR REHABILITATION AND HEALTHCARE	**43 N WHITE HORSE PIKE** **HAMMONTON, NJ 08037**

(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 LIFE SAFETY CODE 101:2012 Existing THIS FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE MINIMUM LIFE SAFETY CODE REQUIREMENTS AS SURVEYED UNDER CMS-2786R.	K 000		
K 211 SS=D	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on documentation review on 8/15/19 and interview on 8/16/19, in the presence of facility management, it was determined that the facility failed to inspect fire doors Annually in accordance with S&C 17-38-LSC. This deficient practice was evidenced by the following: On 8/15/19, a review of the facility's preventative maintenance inspection documentation for the	K 211	1. The maintenance Director immediately did a facility wide inspection on all fire doors and all were found to be incompliance and completed the necessary documentation. No residents were negatively affected. 2. All residents have the potential to be affected by the deficient practice. 3. Administrator educated the Maintenance Director on the regulation for inspecting all fire door assemblies.	9/27/19

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

Electronically Signed | 09/09/2019

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K 211	Continued From page 1 previous 12 months revealed that there was no documented inspections of the facility's fire door assemblies. In an interview, on 8/16/19 at 9:10 AM, the facility's Director of Maintenance stated that he could not find any fire door inspections from the previous Director. NJAC 8:39-31.1(c), 31.2(e) NFPA 80	K 211	The Maintenance director will conduct audits on inspecting all fire door assemblies weekly x 1 month and monthly ongoing to ensure compliance with inspecting fire doors. 4. 4. Administrator/Designee will conduct random monthly audits x12 months to ensure compliance. All findings will be reported to monthly QAPI meeting and decided if further action is necessary.	
K 223 SS=D	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by: Based on observations and interview on 8/15/19, in the presence of facility management, it was determined that the facility failed to maintain self-closing doors to close with the activation of the fire alarm system. This deficient practice was evidenced by the	K 223	1. The Maintenance Director immediately repaired the double doors from the kitchen to the exit corridor and were sufficiently able to close properly when released from the magnetic hold-open device. The door from the kitchen to the main dining room was also	9/27/19

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K 223	Continued From page 2 following: 1. At 12:45 PM, the surveyor and the facility's Director of Maintenance (DM) observed that the double doors from the kitchen to the exit corridor were provided with door closers and were held open by a magnetic hold-open device. When released from the magnet, 1 of the double doors stopped approximately 1-1/2 feet open from the frame. Further observation revealed that the arm of the closer was bent and prevented the door from closing. 2. The surveyor and DM also observed that the door from the kitchen to the main dining room was provided with the same type of door closer assembly. When release from the magnetic hold-open device, the door immediately wedged into the floor and stopped. In an interview, at the time, the DM stated he would have the doors repaired. NJAC 8:39-31.1(c), 31.2(e)	K 223	repaired immediately and was able to close smoothly. No residents were negatively affected. 2. A facility wide inspection was completed on all other self-closing doors in the facility and were found to be in compliance. All residents have the potential to be affected by the deficient practice. 3. The Administrator educated the Maintenance director on the regulation of 'doors with Self-closing devices' in accordance with NFPA. The Maintenance Director will conduct audits on all doors with self-closing devices monthly x 3 months to ensure compliance. 4. The Administrator/Designee will conduct weekly audits x 1 month and monthly x 3 months to ensure compliance. All findings will be brought to monthly QAPI meeting and decided if further action is necessary.	
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test	K 353		9/27/19

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K 353	Continued From page 3 c) Water system supply source Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on documentation review and interview on 8/16/19, and post survey interview on 8/30/19 in the presence of facility management, it was determined that the facility failed to internally inspect the automatic fire sprinkler system every 5 years in accordance with NFPA 25. This deficient practice was evidenced by the following: On 8/16/19, a review of the facility's fire sprinkler system inspection documentation binder revealed that there were no documents indicating when the system was last inspected internally. In an interview, at 11:30 AM, the facility's Director of Maintenance (DM) stated that he was not aware of the last internal inspection of the fire sprinkler system as he was new to the position and would reach out to the inspection vendor. In a post survey interview, on 8/30/19 at 9:30 AM, the DM stated that he was unable to determine the last time the 5 year internal obstruction inspection was performed on the system. NJAC 8:39-31.1(c), 31.2(e) NFPA 13, 25	K 353	1. The facility Sprinkler vendor completed 5 year inspection for automatic fire sprinkler. No residents were negatively affected. 2. A facility wide audit was conducted to ensure all automatic sprinklers were in working condition and in accordance with NFPA 25 and found to be in compliance. All residents have the potential to be affected by the deficient practice. 3. Administrator educated Maintenance director on the proper policy and procedure of internally inspecting the automatic fire sprinkler system every 5 years. The Maintenance director will conduct audits weekly x 1 month and monthly x 3 months to ensure all automatic fire sprinklers are checked appropriately and in accordance with regulation. 4. The administrator/Designee will conduct random weekly audits x 1 month and monthly x 3 months to ensure compliance. All findings will be brought to monthly QAPI meeting and decided if further action is necessary.	

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K 374 SS=D	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observations and interview on 8/15/19, in the presence of facility management, it was determined that the facility failed to ensure that doors in exit corridors were self-closing and would provide at least 20 minutes of fire protection. This deficient practice was evidenced by the following: 1. At 12:50 PM, the surveyor and the facility's Director of Maintenance (DM) observed that the cross-corridor door to the kitchen service area was fully open. Further review, revealed that there was no self-closing device provided to this door and the door would not close automatically in the event of a fire and/or smoke condition. 2. The surveyor also observed that there was no doorknob assembly in the door leaving a clear	K 374	1. A self-closing device was added to the cross-corridor door to the kitchen service area so that it would close automatically in the event of a fire and/or smoke condition and a doorknob was assembled on the door. No residents were negatively affected. 2. A facility wide inspection was completed to ensure all doors in exit corridors closed automatically without interruption and were found to be in compliance. An inspection was done throughout facility to ensure all doors contained doorknobs and were all found to be in compliance. All residents have the potential to be affected by the deficient practice. 3. The Administrator in serviced the Maintenance Director on the proper policy and procedure of Smoke Barrier doors.	9/27/19

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K 374	Continued From page 5 path of travel for smoke and/or fire. In an interview, at the time, the DM stated he would make the correction. NJAC 8:39-31.1(c), 31.2(e)	K 374	The Maintenance Director will conduct weekly audits x 1 month and monthly x 3 months to ensure the cross-corridor door to the kitchen is in compliance. 4. Administrator/Designee will conduct random weekly audits x 1 month and monthly x 3 months to ensure compliance. All findings will be brought to monthly QAPI meeting and decided if further action is necessary.	
K 521 SS=D	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on documentation review and interview on 8/16/19, in the presence of facility management, it was determined that the facility failed to maintain the main boilers and make repairs to the system for compliance. This deficient practice was evidenced by the following: A review of the facility's boiler system inspection documentation, dated 2/21/19, revealed that the licensed inspector identified 2 deficiencies within the 3 hot water boilers and 2 storage tanks. These deficiencies included several piping leaks	K 521	1. On the 3 hot water boilers and 2 storage tanks, the leak in the piping was repaired and the combustion air vent that was clogged with debris was cleaned and cleared of all debris. No residents were negatively affected. 2. An inspection was completed in the facility boiler room to ensure there were no other leaking pipes and no debris in the combustion air vents and all were found to be in compliance. All residents have the potential to be affected by the deficient practice. 3. The Administrator educated	9/27/19

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K 521	Continued From page 6 and a combustion air vent that was clogged with debris. This certification inspection identified a compliance due date of 6/4/19, more than 2 months ago. In an interview, at 9:30 AM, the facility's Director of Maintenance (DM) stated that the vent was cleaned but he piping leaks had not been addressed by the previous Director. There were no certificates of compliance provided for the 5 devices. NJAC 8:39-31.2(e)	K 521	Maintenance Director on the proper policy and procedure on HVAC, heating, ventilation and air conditioning. The Maintenance Director will conduct random weekly audits x 1 month and monthly x 3 months to ensure compliance. 4. Administrator/Designee will conduct weekly audits x 1 month and monthly x 3 months to ensure compliance. All findings will be brought to monthly QAPI meeting and decided if further action is necessary.	