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 _____	**05/13/2021**

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 A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 05/06/21 -05/07/21 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. Hammonton Center is a two story building that was built in 1980's. It is composed of Type 1 fire resistant construction. The facility is divided into 10 smoke zones. The generator will supply power to approximately 30% of the building as per Maintenance Director.	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	K 222		6/30/21

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

Electronically Signed | 05/24/2021

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K 222	Continued From page 1 each door and provisions shall be made for the 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 Elevator lobby exit access door locking in	K 222		

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K 222	Continued From page 2 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 on 05/07/21, 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. The deficient practice was evidenced by the following: The surveyor observed at 11:00 AM, during a tour of the [redacted] floor #[redacted] delayed egress door marked "15-second delay" by resident room [redacted]. The door did not open within 15-seconds. The Assistant Maintenance staff member enguaged the release mechanism (push-bar) by applying continuous pressure. The lock failed to release. The keypad did open the door when the Assistant Maintenance staff member inputted the code. The surveyor verbally informed the facility's Administrator of this finding during the Life Safety Code exit conference at 01:15 PM, NJAC-8:39-31.2(e) NFPA 101:2012 7.2.1.6.1.	K 222	K2220630 1. All Residents can be affected by this deficient practice. Maintenance reached out to facilities Door vendor who came down immediately and fixed the door to ensure it released within the required 15 seconds. Work order will be sent to Phil's email. 2. Maintenance staff will be in serviced on proper egress to ensure doors marked with 15 second delay release within 15 seconds. All other maglock doors will be audited to ensure 15 second release. 3. Maintenance will audit maglock doors weekly times three months to ensure they release within 15 seconds. 4. All audits from the Maintenance Staff will be reviewed at the facilities Monthly QAPI meeting. All concerns from the audits will be addressed.	
K 271 SS=D	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in	K 271		6/30/21

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K 271	Continued From page 3 elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 05/07/21 in the presence of Assistant Maintenance staff member, it was determined that the facility failed to provide exit discharges with a hard packed all-weather travel surface to the common way. This deficient practice was evidenced by the following: On 05/07/21 at 10:30 AM, the Surveyor along with the Assistant Maintenance staff member observed that there were no hard packed surface for evacuation from the following area: The designated exit from [redacted]-wing egress leads to approximately an 10' concrete path, then to an approximately 15' X 15' concete pad that did not extend to the common way (parking lot) road for evacuation. The remaining path consisted of a dirt and grassy area approximately 10' to the road. In an interview with the Assistant Maintenance staff member, he stated he did not realize the concrete evacuation path, did not continue to the common way. The Administrator was notified of the finding at the Life Safety Code exit conference.	K 271	K271 1. All resident can potentially be affected by this deficient practice. Concreate vendor will be out on 6/2 to scope the project. This date was the earliest vendor can come out to our Facility. will send order as soon as work is completed. 2. Maintenance staff will be in serviced on ensuring that all fire exit walkways extend to common areas. All other fire exit walkways have been inspected to ensure that the walkways extend to the common areas. 3. Walkways will be audited quarterly for one year to ensure that they extend to common areas. 4. All audits from the Maintenance Staff will be reviewed at the facilities Monthly QAPI meeting. All concerns from the audits will be addressed.	
K 281 SS=F	NJAC 8:39-31.2(e) Illumination of Means of Egress CFR(s): NFPA 101	K 281		6/30/21

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K 281	Continued From page 4 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide automatic emergency illumination that would operate automatically along the means of egress in accordance with NFPA 101, 2012 LSC Edition, Section 19.2.8, 7.8.1.1, 7.8.1.2. The deficient practice was evidenced by the following: On 05/06/21 and 05/07/21from 09:00 AM, to 01:00 PM, The surveyor observed throughout a tour of the facility that the egress emergency lighting could be shut-off completely in 8 of 8 resident wings. Each nurse station was provided with light switches that would completely shut-off each wing. The wall sconces did remain on when the switches were shut-off , but each wall sconce was provided with an individual switch at each unit and if the switch was shut-off, the area would not be provided with continous emergency illumination. The findings were verified by the Maintenance Director and Assistant Maintenance staff member at the times of the observation's. The Administrator was notified of the findings at the Life Safety Code exit conference. NJAC 8:39-31.2(a)	K 281	K281- 1. All residents can potentially be affected by this deficient practice. Electrician will be on site on 6/17 to correct this deficient practice. Facility will send work order to Phil's email when work is completed. 2. Maintenance staff will be in serviced on ensuring continuous lighting throughout the facility 3. Maintenance staff will audit all wall light sconces effectiveness in terms of continues lighting on a quarterly basis for one year to ensure lighting remains continues. 4. All audits from the Maintenance Staff will be reviewed at the facilities Monthly QAPI meeting. All concerns from the audits will be addressed.	

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K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observation and interview conducted on 05/07/21 in the presence of the Assistant Maintenance and Envionmental Director, it was determined that the facility failed to ensure that the fire suppression system nozzles over the cooking stove were in the proper position to protect against the extension of fire, in accordance with NFPA 96. This deficient practice was evidenced by the	K 324	K324- 1. All Residents can potentially be affected by this deficient practice. Maintenance adjusted the nozzles above the stovetop to the proper position in order to protect against the extension of fire. 2. Maintenance staff was in-serviced on ensuring nozzles remain in the proper position to protect against the extension of fire.	6/30/21

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K 324	Continued From page 6 following: At 09:30 AM, in the facility kitchen, the surveyor observed over the two 6-burner cooking stove's that 3 of 3 fire suppression nozzles were not in the proper position to protect against the extension of fire. The three fire suppression nozzles were directed toward the rear of the working cooking stove and in the event of a fire, would offer no protection against the extension of fire. In an interview with the Assistant Maintenance at the time of the observation, he confirmed that the three fire suppression nozzles at the two working 6-burner cooking stove's were facing the rear of the stove's and would offer no fire protection in the event of a fire. The Administrator was informed of this finding at the Life Safety Code exit conference on 05/07/21 at 1:15 PM. NJAC 8:39-31.2(e) 19.3.2.5.3*(5)(a) NFPA 96	K 324	3. Maintenance staff will audit the nozzles monthly times 3 months to ensure proper positioning. 4. All audits from the Maintenance Staff will be reviewed at the facilities Monthly QAPI meeting. All concerns from the audits will be addressed.	
K 341 SS=F	Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment.	K 341		6/30/21

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K 341	Continued From page 7 Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide notification by audible and visible signals in accordance with NFPA 101, 2012 LSC Edition, Section 19.3.4.3.1, 9.6.3, 9.6.3.2, 9.6.3.6 and NFPA 72, 2010 LSC Edition, Section 18.5, 18.5.2.4, 24.4.2.20.9. The deficient practice was evidenced by the following: 1. On 05/06/21 at approximately 12:05 PM observation revealed was no horn/strobe tied to the fire alarm in the [redacted] Lounge enclosed courtyard. 2. On 05/06/21 at approximately 12:15 PM observation revealed was no horn/strobe tied to the fire alarm in the [redacted] enclosed courtyard. The findings were verified by the Maintenance Director and Assistance Maintenance staff member at the time of the observation's. The Administrator was notified of the findings at the Life Safety Code exit conference at 01:15 PM, on 05/07/21.	K 341	K341- 1. All Residents have the potential to be affected by this deficient practice. Fire alarm vendor will be onsite on 6/16/2021 to install the Horn strobes. Horn strobes will be added to the go lounge enclosed courtyard and the [redacted] enclosed courtyard. A copy of the work order will be submitted once completed. 2. Maintenance staff will audit the outdoor patio areas on a quarterly basis for 1 year to ensure audible and visible signals are in working condition. 3. Maintenance staff was in serviced on ensuring all other outdoor patio areas had Horn strobes. All other outdoor patio areas were audited to ensure audible and visible signals for fire safety. 4. All audits from the Maintenance Staff will be reviewed at the facilities Monthly QAPI meeting. All concerns from the audits will be addressed.	
K 353 SS=F	NJAC 8:39-31.2(a) Sprinkler System - Maintenance and Testing CFR(s): NFPA 101	K 353		6/30/21

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K 353	Continued From page 8 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 _____ 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 observation and interview, the facility failed to maintain the sprinkler system, ensuring the ceiling level was smoke resisting in accordance with NFPA 101, 2012 Edition, Section 19.3.5.1, 4.6.12, 8.5.6, 8.5.6.2 and 9.7. NFPA 25, 2011 Edition, Section 5.1, 5.2.2.1. The deficient practice of failing to provide a complete smoke resisting ceiling at the level of the installed sprinklers would not ensure prompt and proper operation of the sprinklers. The deficient practice was evidenced by the following: The building tour started on 05/07/21 at 9:12 AM, to 1:00 PM, 1. The surveyor observed in the [redacted] Server room that the ceiling tile frame was installed level with	K 353	K353- 1. All resident can potentially be affected by this deficient practice. Ceiling tiles were installed in the B-1 server room, Resident room [redacted] floor nourishment room, Beauty salon room, Activities storage room by the floor [redacted] elevator, Basement air exchange room, housekeeping environment room, medical records office, Medical Records office closet and Fire alarm panel room. The escutcheons on corridor [redacted] wing have been installed. 2. All other areas of the facility were inspected by the Maintenance staff to ensure ceiling level was smoke resistant. Maintenance staff inspected all other areas of the facility to ensure escutcheons were properly installed. Maintenance staff was in serviced on ensuring that the	

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K 353	Continued From page 9 the fire sprinkler head, but no ceiling tiles were in place.(approximately 10 tiles) that would now allow hot gases and smoke pass the sprinkler into the space above. 2. The surveyor observed in resident room [redacted] that a 2' x 1' ceiling tile was missing in the resident bathroom that would now allow hot gases and smoke pass the sprinkler into the space above. 3. The surveyor observed in [redacted] wing that in the corridor 10 fire sprinkler heads were missing escutcheon plates, that would now allow hot gases and smoke pass the sprinkler into the space above. 4. The surveyor observed in the [redacted] floor nourishment room by the nurse station that a 1' x 3' ceiling tile was missing, that would now allow hot gases and smoke pass the sprinkler into the space above. 5. The surveyor observved in the occupied Beauty Salon that a 2' x 2' ceiling tile was missing, that would now allow hot gases and smoke pass the sprinkler into the space above. 6. . The surveyor observved in the Activities storage room by the floor[redacted] elevators that a1' x 2' ceiling tile was missing, that would now allow hot gases and smoke pass the sprinkler into the space above. 7. The surveyor observved in the basement air exchange room that a 2' x 4' angle cut ceiling tile was missing, that would now allow hot gases and smoke pass the sprinkler into the space above. 8. . The surveyor observved in the	K 353	ceiling level remains smoke resist with proper ceiling tile placement. They will also be in serviced on proper escutcheons placement. 3. Maintenance staff will audit all other areas of the facility quarterly for one year to ensure ceiling tile gaps are filled with ceiling tiles and missing escutcheons are installed. 4. All audits from the Maintenance Staff will be reviewed at the facilities Monthly QAPI meeting. All concerns from the audits will be addressed.	

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K 353	Continued From page 10 housekeeping/environment room that two 2' x 4' ceiling tiles was missing, that would now allow hot gases and smoke pass the sprinkler into the space above. 9. . The surveyor observved in the medical records office two 2' x 4' ceiling tile was missing, that would now allow hot gases and smoke pass the sprinkler into the space above. 10. . The surveyor observved in the medical records office closet that a 2' x 4' ceiling tile was missing, that would now allow hot gases and smoke pass the sprinkler into the space above. 11. . The surveyor observved in the fire alarm panel room that a 8" x 6" ceiling tile was missing, that would now allow hot gases and smoke pass the sprinkler into the space above. An interview was conducted during the observations with the Assistant Maintenance Director and he agreed and stated that the ceiling tiles were missing and 10 eschutcheon plates in the A1 wing corridor were missing or had bad ceiling cuts around the fire sprinkler heads.that would allow hot gases and smoke pass the sprinkler into the space above. The Administrator was notified of the findings at the Life Safety Code exit conference.	K 353		
K 374 SS=E	NJAC 8:39-31.2(e) 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	K 374		6/30/21

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K 374	Continued From page 11 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 observation and interview on 05/07/21, in the presence of the Assistant Maintenance staff member and the Environmental Director, it was determined that the facility failed to maintain 2 of 14 smoke barrier doors to automatically close with the activation of the fire alarm system to provide at least 20 minutes of fire protection. This deficient practice was evidenced by the following: 1. At 10:15 AM, the surveyor observed in the C-wing that the smoke barrier door set near resident room [redacted] did not close when released from the magnetic hold-open device. When released, one of the double doors remained open approximately 4 inches, due to not enough pressure on the door closing device to fully close the door preventing it from being smoke resistive. 2. At 10:58 AM, the surveyor observed that the double doors in the kitchen did not fully close, when released from the magnetic hold-open device. One of the double doors remained open in its frame, approximately 1/2 inch preventing it from being smoke resistive.	K 374	K374- 1. All Residents can potentially be affected by this deficient practice. The smoke Barrier door set near Resident room [redacted] was fixed to fully close when released from the magnet. The double doors in the kitchen were fixed too fully close when released from the magnet. 2. All other smoke barrier double doors in the facility were inspected to ensure that they fully close when released from the magnets. Maintenance staff was in-serviced on ensuring that smoke barrier doors fully close when released from magnet holds. 3. Maintenance Staff will audit smoke barrier doors weekly times 3 months to ensure that they fully close when released from the magnet. 4. All audits from the Maintenance Staff will be reviewed at the facilities Monthly QAPI meeting. All concerns from the audits will be addressed.	

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	315209	A. BUILDING **01** B. WING _____	**05/13/2021**

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K 374	Continued From page 12 In an interview at the time of the observation's, the Assistant Maintenance man stated and confirmed that the smoke doors should close fully. The Administrator was notified of the finding at the Life Safety Code exit conference.	K 374		
K 531 SS=E	NJAC 8:39-31.1(c), 31.2(e) Elevators CFR(s): NFPA 101 Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3 This REQUIREMENT is not met as evidenced by: Based on observation and interview conducted on 05/05/21, in the presence of the Maintenance Director, it was determined that the facility failed to maintain an elevator emergency audible alarm for 2 of 2 elevators, in accordance with ASME/ANSI A17.3.	K 531	K531- 1. All Residents have the potential to be affected by this deficient practice. Elevator vendor stated that they will be on site the week of 6/13/21 to fix both elevator phones. A work order will be forwarded as	6/30/21

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K 531	Continued From page 13 This deficient practice was evidenced by the following: 1. At 11:10 A.M., the surveyor had the Maintenance Director conduct a test of the the elevator emergency communication telephone system in elevator #1. The emergency communication telephone did not work. 2. At 11:25 A.M., the surveyor had the Maintenance Director conduct a test of the the elevator emergency communication telephone system in elevator #2. The emergency communication telephone did attempt to call, but the speaker produced to low of a volume for any emergency communication. An interview was conducted during the observations with the Maintenance Director and he acknowledged and agreed that the elevator emergency communication telephone system did not work propperly. The Administrator was notified of the findings at the Life Safety Code exit conference. NJAC 8:39-31.2(e) ASME/ANSI A17.3.	K 531	soon as work is completed. 2. Maintenance staff was in serviced on ensuring that the emergency communication telephone in the elevators works at all times and is functioning with a volume level that is audible. 3. Maintenance staff will audit the elevators weekly times 3 months to ensure emergency communication telephones that are in the elevators are working and functioning properly. 4. All audits from the Maintenance Staff will be reviewed at the facilities Monthly QAPI meeting. All concerns from the audits will be addressed.	
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	K 920		6/30/21

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K 920	Continued From page 14 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. 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 the facility did not prohibit the use of power strips beyond temporary installation, as a substitute for adequate wiring, exceeding 75% of the capacity and the proper use of power strips in accordance with the requirements of NFPA 101, 2012 LSC Edition, Section 19.5, 19.5.1, 9.1, 9.1.2. NFPA 70, 2011 LSC Edition, Section 400.8 and 590.3 (D). NFPA 99, 2012 LSC Edition, Section 10.2.3.6 and 10.2.4. This deficient practice does not ensure prevention of an electrical fire or electric shock hazard for high draw appliances and was evidenced by the following:: 1. At approximately 10:10 A.M., observation revealed in the [redacted] Unit Manager office, that a refridgerator was plugged into an multi-outlet power strip. The multi-outlet power strip was then plugged into a green extension cord that was plugged into the duplex wall outlet behind the	K 920	K920 1. All Residents have the potential to be affected by this deficient practice. The power strip and extension cord that was located in the [redacted] Unit Managers office was removed. The Power strip that was located in the Activities room was removed. 2. All other areas of the facility were inspected to ensure no use of power strips or extension cords. Department Heads were in serviced on not using power strips or extension cords. 3. Maintenance will audit areas of the facility quarterly for 1 year to ensure that no power strips or extension cords are in use. 4. All audits from the Maintenance Staff will be reviewed at the facilities Monthly QAPI meeting. All concerns from the audits will be addressed.	

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K 920	Continued From page 15 desk. The high draw appliance must be plugged directly into an electrical outlet. 2. At approximately 11:00 A.M., observation revealed in the Activities room that a refridgerator and microwave were plugged into a multi-outlet power strip. The power strip was then plugged into the duplex wall outlet. The findings were verified by the Assistant Maintenance staff member at the time of the observations. The Administrator was notified of the findings at the Life Safety Code exit conference. NJAC 8:39-31.2(e)	K 920		