	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		315209	B. WING		06/05/2023
IAME OF PH	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
IAMMON	TON CENTER FOR RE	EHABILITATION AND HEALTHCARE		43 N WHITE HORSE PIKE HAMMONTON, NJ 08037	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
K 000	INITIAL COMMEN	TS	K 00	D	
K 222 SS=E	New Jersey Depart Survey and Field C 05/19/2023 and Ha Rehabilitation and noncompliance with participation in Med 483.90(a), Life Safe Edition of the Fire F 101, Life Safety Co EXISTING Health C Hammonton Center Healthcare is a Two building that was b facility is divided in facility has one Die Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required equipped with a lat use of a tool or key using one of the fol arrangements: CLINICAL NEEDS LOCKING Where special lock clinical security nee only one locking de each door and prov rapid removal of oc locks; keying of all	r For Rehabilitation and o-story, Type I Fire Resistant uilt in January 1984. The to 13 smoke zones. The sel emergency generator. I means of egress shall not be ch or a lock that requires the from the egress side unless lowing special locking OR SECURITY THREAT ing arrangements for the eds of the patient are used, evice shall be permitted on visions shall be made for the coupants by: remote control of locks or keys carried by staff at such reliable means available	K 22	2	6/22/23

Electronically Signed

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.

06/22/2023

	S FOR MEDICARE &		0.00			IO. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	· · ·	E SURVEY IPLETED
		315209	B. WING		0	6/05/2023
IAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	E	
IAMMON	TON CENTER FOR REH	ABILITATION AND HEALTHCARE		43 N WHITE HORSE PIKE HAMMONTON, NJ 08037		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE
K 222	Continued From page		K 22	2		
		CKING ARRANGEMENTS g arrangements for the				
	safety needs of the p	atient are used, all of the				
	Clinical or Security Locking requirements are being met. In addition, the locks must be					
		ail safely so as to release				
		the device; the building is vised automatic sprinkler				
	system and the locke	d space is protected by a				
	complete smoke dete constantly monitored	at an attended location				
	within the locked spa	ce); and both the sprinkler				
	and detection system doors upon activation	is are arranged to unlock the n.				
	18.2.2.2.5.2, 19.2.2.2	2.5.2, TIA 12-4				
	DELAYED-EGRESS	LOCKING				
		yed-egress locking systems				
		ce with 7.2.1.6.1 shall be semblies serving low and				
	ordinary hazard conte	ents in buildings protected				
		oroved, supervised automatic or an approved, supervised				
	automatic sprinkler s	ystem.				
	18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROL	LED EGRESS LOCKING				
	ARRANGEMENTS					
		gress Door assemblies ce with 7.2.1.6.2 shall be				
	permitted.					
	18.2.2.2.4, 19.2.2.2.4	EXIT ACCESS LOCKING				
	ARRANGEMENTS					
	Elevator lobby exit ac	ccess door locking in 1.6.3 shall be permitted on				
	door assemblies in b	uildings protected throughout				
	by an approved, supe	ervised automatic fire I an approved, supervised				

Facility ID: NJ60113

If continuation sheet Page 2 of 31

		MEDICAID SERVICES				B NO. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION 6 01	· · ·	DATE SURVEY COMPLETED
		315209	B. WING			06/05/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
HAMMON	TON CENTER FOR REH	ABILITATION AND HEALTHCARE		43 N WHITE HORSE PIKE HAMMONTON, NJ 08037		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIO DATE
K 222	Continued From page	e 2	К 22	2		
	by:			1. Facility removed the knob	latches from	
p 0 fa d a irr e rr 1 F C S s rr M C S s rr M C S S V V	05/19/2023, it was de failed to provide 1 of doors in the means o			the front entrance doors. All c Doors of the facility have bee No Additional knob latches ha discovered as a result of this 2. All resident can be affected deficient practice. Dir. of Mair all Maintenance personal have	n audited. ave been audit. I by this htenance and	
	requirements of NFP/ 19.2.2.2.5.1, 19.2.2.2 Findings include:	A 101, 2012 Edition, Section .5.2 and 19.2.2.2.6.		serviced on NFPA 101 related with specificity on the require knob latches cannot be instal doors used for means of Egre	ment that I on any ess.	
	survey entrance at ap request was made to Manager (AMM) and Director (EVSD) to pr	one of survey) during the oproximately 8:45 AM, a the Assistant Maintenance Environmental Services ovide a copy of the facility		3. Dir of Maintenance will aud facility weekly x 4 weeks and x 3 months or until compliance to ensure that no latches hav installed on any doors used for Egress.	then monthly e is reached e been or means of	
	lay-out which identifies the various rooms. A review of the facility provided lay-out identified the facility is a two-story building with eleven designated exit discharge doors (illuminated exit signs above doors) that Resident, Staff and Visitors would use in the event of an emergency to exit the building.			4. All the Maintenance Direct be presented during the facili QAPI meeting. All concerns v discussed and addressed im	ties monthly vill be	
	•	tely 9:22 AM on 05/18/2023 19/2023 in the presence of Ir of the building was				
	facility the surveyor in	y building tour the of the nspected eleven (11) arge doors with the following				

Facility ID: NJ60113

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		ID HUMAN SERVICES MEDICAID SERVICES			FOR	D: 02/20/202 M APPROVEI O. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING 0 1	CONSTRUCTION		E SURVEY PLETED
		315209	B. WING		06	/05/2023
NAME OF PI	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
		ABILITATION AND HEALTHCARE	43	N WHITE HORSE PIKE		
	TON OLIVIENT ON NEW		H	AMMONTON, NJ 08037		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
K 222	Continued From page	e 3	K 222			
	the surveyor observe sets of automatic slid (internal set of doors revealed thumb turn l					
	event of an emergend Thumb turn locks and	that read, Push here in the cy. I fastening device on the hergency use of the exit.				
	The AMM confirmed to observations.	the findings at the times of				
	On 05/19/2023 during approximately 12:57 the Administrator of th	PM, the surveyor informed				
	NJAC 8:39 -31.2 (e)					
K 311 SS=D			K 311			6/22/23
	shafts, chutes, and of between floors are er	hafts, light and ventilation				

Facility ID: NJ60113

If continuation sheet Page 4 of 31

		MEDICAID SERVICES				NO. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	PLE CONSTRUCTION	· · · ·	TE SURVEY MPLETED
		315209	B. WING			6/05/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
HAMMON	TON CENTER FOR REH	ABILITATION AND HEALTHCARE		43 N WHITE HORSE PIKE HAMMONTON, NJ 08037		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	CTION SHOULD BE) THE APPROPRIATE	(X5) COMPLETIO DATE
K 311	Continued From page	e 4	K 31	11		
	resistance rating, also box.	g at least a 2-hour fire o check this is not met as evidenced				
	Based on observatio documentation on 05 the presence of facilit determined that the fa of 14 exit access stai	ns and review of facility /18/2023 and 05/19/2023, in ty Management it was acility failed to ensure that 1 rwell doors tested, were ng the 1-1/2 hour fire rated		1. On 5/18/2023 Mainten Department immediately fixed the existing door kno latch upon closure of the doors used for means of doorknobs installed on th audited to ensure that the	addressed and ob to positively door. All other Egress that have em, have been ey positively latch	
	This is evidenced by	the following,		upon closure of the door. issues have been discove of this audit.		
		one of survey) during the		2. All residents can be aff		
	- ·	pproximately 8:45 AM, a		deficient practice. Dir of N		
	Manager (AMM) and	the Assistant Maintenance Environmental Services		all Maintenance personne serviced on NFPA 101 re	lated to vertical	
	Director (EVSD) to pr lay-out which identifie	rovide a copy of the facility as the various rooms.		openings with specificity of positively latching for all e		
	the facility is a two-st with fourteen (14) des (illuminated exit signs	isitors would use in the		 doors. 3. Dir of Maintenance will facility weekly x 4 weeks x 3 months or until compl to ensure that all exit doo upon closure. 4. All the Maintenance Di be presented during the f 	and then monthly iance is reached rs positively latch rectors audits will	
		ately 9:22 AM on 05/18/2023 19/2023 in the presence of Ir of the building was		QAPI meeting. All concer discussed and addressed		
	facility the surveyor in closure test of fourtee	y building tour the of the nspected and conducted en (14) exit access doors ways with the following				

Facility ID: NJ60113

If continuation sheet Page 5 of 31

		MEDICAID SERVICES				IO. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION 01	· · ·	TE SURVEY MPLETED
		315209	B. WING		0	6/05/2023
NAME OF P	ROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP CODE		
HAMMON	TON CENTER FOR REH	ABILITATION AND HEALTHCARE		43 N WHITE HORSE PIKE HAMMONTON, NJ 08037		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
K 311	Continued From page	e 5	К 31	1		
	On 05/19/2023,					
	test of the first (1st.) f Services) corridor exidoor was opened to a	11:33 AM, during a closure floor stairway (next to Social it access door, when the a 90 degree opening to the ed to self-close, the door did its frame.				
	the same results.	ned two additional times with ed the door had no means to frame.				
	into its frame to main construction to preve	rould need to positive latch tain the 1-1/2 hour fire rated nt fire, smoke and enter the exit stairwell in the				
	The AMM confirmed observations.	the finding at the time of				
	survey exit at approx	g the Life Safety Code imately 12:57 PM, the e Administrator of the				
	Fire Safety Hazard.					
K 321 SS=E	NJAC 8:39- 31.2(e) Hazardous Areas - E CFR(s): NFPA 101	nclosure	K 32	1		6/22/23
		nclosure protected by a fire barrier sistance rating (with 3/4 hour				

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 02/20/20 FORM APPROV OMB NO. 0938-03
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G 01	(X3) DATE SURVEY COMPLETED
		315209	B. WING		06/05/2023
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	-
HAMMON	TON CENTER FOR REH	ABILITATION AND HEALTHCARE		43 N WHITE HORSE PIKE	
_		-		HAMMONTON, NJ 08037	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLÉTIC
K 321	system in accordance When the approved a system option is used separated from other partitions and doors i Doors shall be self-cl and permitted to have protective plates that from the bottom of the Describe the floor and hazardous areas that 19.3.2.1, 19.3.5.9 Area Separation N// a. Boiler and Fuel-Fir b. Laundries (larger ti c. Repair, Maintenand d. Soiled Linen Room e. Trash Collection R (exceeding 64 gallons f. Combustible Storag (over 50 square feet) g. Laboratories (if cla Hazard - see K322) This REQUIREMENT by: Based on observatio documentation on 05 the presence of facilit determined that the fa fire-rated doors to ha self-closing, and were resisting partitions in 2012 Edition, Section	automatic fire extinguishing e with 8.7.1 or 19.3.5.9. automatic fire extinguishing d, the areas shall be spaces by smoke resisting n accordance with 8.4. osing or automatic-closing e nonrated or field-applied do not exceed 48 inches e door. d zone locations of t are deficient in REMARKS. Automatic Sprinkler A ed Heater Rooms han 100 square feet) ce, and Paint Shops ns (exceeding 64 gallons) ooms s) ge Rooms/Spaces ssified as Severe T is not met as evidenced on and review of facility /18/2023 and 05/19/2023 in ty management, it was acility failed to ensure that	К 3	 1. The Maintenance department adjusted the Dietary dry storage do the Medical Records storage room ensure that these doors self-close their frame upon closure. 2. All residents can be affected by deficient practice. Dir. of Maintenar all Maintenance personal have bee serviced on NFPA 101 related to Hazardous areas □ enclosures to a that all self-closing doors self-close 	door to into this nce and en in ensure

Facility ID: NJ60113

If continuation sheet Page 7 of 31

		MEDICAID SERVICES			OMB NO.	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDIN	PLE CONSTRUCTION G 01	(X3) DATE S COMPL	
		315209	B. WING		•	5/2023
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	CODE	
HAMMON	TON CENTER FOR REH	ABILITATION AND HEALTHCARE		43 N WHITE HORSE PIKE HAMMONTON, NJ 08037		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLETIO DATE
K 321	Continued From page	e 7	К 32	21		
	This deficient practiced was evidenced by the following: their frames upon closure. 3. Dir of Maintenance will audit all facility weekly x 4 weeks and ther		l audit all areas of and then monthly			
	On 05/18/2023 (day one of survey) during the survey entrance at approximately 8:45 AM, a request was made to the Assistant Maintenance Manager (AMM) and Environmental Services Director (EVSD) to provide a copy of the facility lay-out which identifies the various rooms.			 x 3 months or until complete to ensure that all doors fi upon closure. 4. All the Maintenance Dibe presented during the figure QAPI meeting. All concerts 	t into their frames irectors audits will facilities monthly	
		y provided lay-out identified ory building and a basement.		discussed and addressed	d immediately	
		ately 9:22 AM on 05/18/2023 e facility AMM a tour of the ed.				
	Along the tour of the observed the followin to have smoke resisti	g hazardous area that failed				
	On 05/18/2023:					
	 At approximately s the Medical records s basement was perfor 	-				
	into the Medical record did not self-close into	of the corridor door leading rds storage room, the door its frame. The surveyor tible boxes of medical				
	This test was repeate the same results.	ed two additional times with				
	The room was larger	than 50 square feet.				
	With this corridor doo	or not self-closing this would				

		ID HUMAN SERVICES MEDICAID SERVICES				F	ITED: 02/20/2024 ORM APPROVEE NO. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		NSTRUCTION		DATE SURVEY COMPLETED
		315209	B. WING				06/05/2023
NAME OF PI	ROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE	I	
HAMMON		ABILITATION AND HEALTHCARE		43 N	WHITE HORSE PIKE		
	TON CENTER FOR REIN	ADIENTATION AND THEAETHOAKE		HAM	IMONTON, NJ 08037		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
K 321	Continued From page	e 8	КЗ	321			
	allow fire, smoke and	poisonous gases to pass orridor in the event of a fire.					
		10:03 AM, an inspection of bom in the basement was					
	During a closure test of the corridor door leading into the Dietary storage room the door did not self-close into its frame. The surveyor observed combustible boxes and other combustible products in the room.						
	This closure test was times with the same r	repeated two additional results.					
		ed and recorded opening of the door to the gap between the door and					
	-	red and recorded the room 1 feet (294 square feet) 60 square feet.					
	allow fire, smoke and	r not self-closing this would poisonous gases to pass orridor in the event of a fire.					
	posted on the corrido that you would need	ency evacuation diagram r wall in the area identified to pass these rooms as the dary egress route out of the fire.					
	The AMM confirmed	the findings at the time.					
		g the Life Safety Code imately 12:57 PM, the					

Facility ID: NJ60113

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 02/20/202 FORM APPROVE OMB NO. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING 0 1	CONSTRUCTION I	(X3) DATE SURVEY COMPLETED
		315209	B. WING		06/05/2023
NAME OF PI	ROVIDER OR SUPPLIER		ST	TREET ADDRESS, CITY, STATE, ZIP CODE	-
HAMMON	TON CENTER FOR REH	ABILITATION AND HEALTHCARE		3 N WHITE HORSE PIKE AMMONTON, NJ 08037	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
K 321	Continued From page	e 9	K 321		
	surveyor informed the deficiency.				
	NJAC 8:39-31.2 (e)				
K 341 SS=E	· · · · · · · · · · · · · · · · · · ·		K 341		6/22/23
	components approve accordance with NFF and NFPA 72, Nation provide effective ward building. In areas not detection is installed unit. In new occupand at notification applian and supervising station	s installed with systems and d for the purpose in PA 70, National Electric Code, al Fire Alarm Code to ning of fire in any part of the continuously occupied, at each fire alarm control cy, detection is also installed ice circuit power extenders, on transmitting equipment. ring or other transmission for integrity.			
	by: Based on observation facility provided docut and 05/19/2023, in the management, it was failed to provide fire a and visible signals for courtyards in accorda LSC Edition, Section	T is not met as evidenced on, interview and review of mentation on 05/18/2023 the presence of the facility determined that the facility alarm notification by audible r 1 of 3 outside enclosed ance with NFPA 101, 2012 o 19.3.4.3.1, 9.6.3, 9.6.3.2, 2, 2010 LSC Edition, Section		1. Facility has engaged the services of facilities fire alarm vendor to install a audio and visual alarm in the second fl smoke patio area to ensure that reside and staff who are outside on the patio notified of emergencies. All other area the facility have been audited to ensure that areas requiring the audible and vis alarm have them installed and are in	loor ents are as of e

L

Event ID: Q82921

Facility ID: NJ60113

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					CONSTRUCTION		
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING		CONSTRUCTION	· /	
		315209	B. WING			DULD BE COMPLE ROPRIATE DATE y this DATE ance and Date been in fire o and Date dio and Date II areas of n monthly reached ility/ alled. audits will monthly Date	6/05/2023
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
HAMMON	TON CENTER FOR REH	ABILITATION AND HEALTHCARE		43 N WHITE HORSE PIKE HAMMONTON, NJ 08037			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETIO DATE
K 341	Continued From page	e 10	K 34	11			
	18.5, 18.5.2.4, 24.4.	2.20.9			working order.		
					2. All residents can be affected by this		
	The deficient practice following:			deficient practice. Dir of Maintenance all Maintenance personnel have been serviced on NFPA 101 related to fire			
	On 05/18/2023 (day	one of survey) during the			alarm system installation of audio and		
		pproximately 8:45 AM, a			visual alarms with specificity on		
		the Assistant Maintenance			requirement of installations of Audio a	nd	
		Environmental Services			visual alarms.	_	
	, , ,	rovide a copy of the facility			3. Dir of Maintenance will audit all area		
	lay-out which identifie	es the various rooms.			facility weekly x 4 weeks and then mo		
	A review of the facility	y provided layout identified			x 3 months or until compliance is reac to ensure that all areas of the facility/	neu	
	the facility as a two-s				patios requiring the installation of audi	o/	
	basement.				visual alarms will have them installed.		
					4. All the Maintenance Directors audits	s will	
		ately 9:22 AM on 05/18/2023			be presented during the facilities mont	thly	
		/19/2023 in the presence of			QAPI meeting. All concerns will be		
		tour of the building was			discussed and addressed immediately	/.	
	-	e two day tour of the facility, ed three (3) outside enclosed					
	Resident courtyards						
	On 05/18/2023 at ap	proximately 12:08 PM, the					
	-	the second (2nd) floor					
		nclosed smoking area that					
	-	ave an audio and visual ent, Staff, and Visitors of an					
	-	ling's fire alarm system.					
		eyor asked the AMM, "Do					
		nd visual alarm tied into the					
	around and told the s	ystem." The AMM looked surveyor, no.					
	The AMM confirmed	the findings at the time.					
		g the Life Safety Code imately 12:57 PM, the					

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			()(0)			<u>8-039</u>
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING (E CONSTRUCTION 01	(X3) DATE SURVE COMPLETED	
		315209	B. WING		RECTION SHOULD BE PPROPRIATE	23
NAME OF PI	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
HAMMON	TON CENTER FOR REH	ABILITATION AND HEALTHCARE		43 N WHITE HORSE PIKE HAMMONTON, NJ 08037		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMP	(X5) PLETIC DATE
K 341	Continued From page	• 11	K 341			
	surveyor informed the deficiency.	Administrator of the				
	NJAC 8:39-31.2(a)					
K 351	9.6.3, 9.6.3.2, 9.6.3.	Edition , Section 19.3.4.3.1, 6 and NFPA 72, 2010 LSC 18.5.2.4, 24.4.2.20.9 stallation	K 351		6/22/2	23
SS=E						
	Spinkler System - Ins 2012 EXISTING	tallation nospitals where required by				
	construction type, are approved automatic s	protected throughout by an prinkler system in				
	Installation of Sprinkle	A 13, Standard for the er Systems. ruction, alternative protection				
	measures are permitt	ed to be substituted for specific areas where state				
	In hospitals, sprinkler closets of patient slee	s are not required in clothes ping rooms where the area				
	sprinkler coverage co required by NFPA 13, Sprinkler Systems.	exceed 6 square feet and vers the closet footprint as Standard for Installation of				
	19.4.2, 19.3.5.10, 9.7	.3.5.3, 19.3.5.4, 19.3.5.5, , 9.7.1.1(1) is not met as evidenced				
	Based on observatio provided documentat 05/19/2023, in the pre	n and review of facility on on 05/18/2023 and esence of facility etermined that: 1) The		1. All damaged or missing ceiling ti for 2nd floor janitors closet were repla on 5/19, ceiling tiles for the Activities office, B wing server room, B wing so	aced Dir	
	Facility failed to prope	erly install sprinklers, as Jation §483.90(a) physical		room, D wing janitors closet have be replaced on 5/22 with new ceiling tile	en	

Facility ID: NJ60113

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						NO. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION G 01	· · · ·	ATE SURVEY OMPLETED
		315209	B. WING			06/05/2023
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
HAMMON	TON CENTER FOR REH	ABILITATION AND HEALTHCARE		43 N WHITE HORSE PIKE HAMMONTON, NJ 08037		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
K 351	Continued From page	e 12	K 35	51		
	requirements of NFP/ 19.3.5.1, 9.7, 9.7.1.1 Association (NFPA) 1 Systems 2012 Edition New Jersey Uniform 0 5:23, for use group I- occupancy. The deficient practice following: On 05/18/2023 (day of survey entrance at ap request was made to Manager (AMM) and Director (EVSD) to pr layout which identifies A review of the facility the facility as a two-st basement. Starting at approxima and continued on 05/ the facility AMM, a too conducted. Along the surveyor observed th failed to provide prop On 05/18/2023, 1) At approximately f	e is evidenced by the one of survey) during the oproximately 8:45 AM, a the Assistant Maintenance Environmental Services rovide a copy of the facility is the various rooms. If provided layout identified tory building with a attely 9:22 AM on 05/18/2023 19/2023 in the presence of		other ceiling tiles of the facility h audited to ensure that no other are damaged or missing. All cei that were damaged or missing r the audit, have been replaced w ceiling tiles. 2. All residents can be affected deficient practice. Dir of Mainter all Maintenance personnel have serviced on NFPA 101 related to system installations with specific requirement that all areas of the that require ceiling tiles have the installed and are not damaged. 3. Dir of Maintenance will aud of facility weekly x 4 weeks and monthly x 3 months or until com reached to ensure that all areas facility which require ceiling tiles them installed with no damaget 4. All the Maintenance Directo will be presented during the faci monthly QAPI meeting. All conc be discussed and addressed im	ceiling tiles ing tiles ing tiles ioted on ith new d by this nance and been in o Sprinkler city on the facility em it all areas then pliance is of the have o them. ors audits lities erns will	
	2) At approximately	11:34 AM, inside the 2nd. s office, the drop ceiling was				

Facility ID: NJ60113

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		MEDICAID SERVICES				<u>D. 0938-039</u> E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	E CONSTRUCTION 01	· · ·	PLETED
		315209	B. WING		06	/05/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE	
HAMMON	TON CENTER FOR REH	ABILITATION AND HEALTHCARE		43 N WHITE HORSE PIKE HAMMONTON, NJ 08037		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE
K 351	Continued From page	e 13	K 35			
	missing one (1) 2' by tiles from the grid.	4' and two (2) 2' by 2' ceiling				
	On 05/19/2023,					
	server room, there w	10:34 AM, inside the B-Wing ere several wires running es leaving openings in the				
	scale room basemen	10:40 AM, inside the B-Wing t level Electrical room, the sing two (2) 2' by 4' ceiling				
	5) At approximately D-Wing Janitor's clos missing Two (2) ceilir	et, the drop ceiling was				
	fire, the heat would b	he ceilings, in the event of a ypass the fire sprinkler in the the fire sprinkler system.				
	The AMM confirmed	the findings at the time.				
	survey exit at approx	g the Life Safety Code imately 12:57 PM, the e Administrator of the				
	Fire Safety Hazard.					
	NJAC 8:39-31.1(c), 3	1.2(e)				
	NFPA 13					
	Portable Fire Extingu CFR(s): NFPA 101	ishers	K 35	5		6/22/23

Event ID: Q82921

Facility ID: NJ60113

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		ID HUMAN SERVICES			PRINTED: 02/20/2024 FORM APPROVED
TATEMENT C	S FOR MEDICARE &	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION 01	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED
		315209	B. WING		06/05/2023
NAME OF PR	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP CODE	
				43 N WHITE HORSE PIKE	
HAMMON	TON CENTER FOR REH	ABILITATION AND HEALTHCARE		HAMMONTON, NJ 08037	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION
K 355	Continued From page Portable Fire Extinguis inspected, and mainta NFPA 10, Standard for Extinguishers. 18.3.5.12, 19.3.5.12, This REQUIREMENT by: Based on observatio documentation on 05 the presence of facilit determined that the fa 1) Perform Hydrostat extinguishers, as required by Nation Association NFPA 10 19.3.5.12, 9.7.4.1 and Association (NFPA) 1 6.1, 6.1.3.8.1 and 6.1 Reference #1 NFPA for portable fire exting - 4- 3 Inspection Ma - 4- 3.1 Frequency. inspected when initial thereafter at approxim extinguishers shall be intervals when circum - 4- 3.3 Corrective A of any fire extinguishers	e 14 ishers shers are selected, installed, ained in accordance with or Portable Fire NFPA 10 is not met as evidenced in and review of facility 5/18/2023 and 05/19/2023 in y management, it was acility failed to: tic testing for 16 of 28 fire nal Fire Protection 01, 2012 Edition, Section d National Fire Protection 0, 2010 Edition, Sections .3.8.3. and N.J.A.C. 5:70. 10 Edition 2010 Standard guishers reads, aintenance. Fire extinguishers shall be ly placed in service and nately 30-day intervals. Fire e inspected at more frequent istances require. ction. When an inspection er reveals a deficiency in any 3.2 (a), (b), (h), and (i),	K 355		oom, he a, near oond D4, om D ing hment ent at dor or ass K have All at nd will per the fire en

Facility ID: NJ60113

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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING			E SURVEY IPLETED
		315209	B. WING		00	6/05/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	00	0/05/2025
				43 N WHITE HORSE PIKE		
HAMMON	TON CENTER FOR REH	ABILITATION AND HEALTHCARE		HAMMONTON, NJ 08037		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
K 355	12-year hydrostatic te subjected to the appl procedures. The rem agent fire extinguishe a listed halon recover applicable maintenan performed during per hydrostatic testing, th be from that date. - 7.3.1.1.1 Fire extin to maintenance at int years at the time of h specifically indicated electronic notification The findings include to Manager (AMM) and Director (EVSD) to per layout which identifie A review of the facility the facility as a two-se basement. Starting at approxima and continued on 05/ the facility's AMM, a te conducted. During the two (2) dat	extinguishers shall require a est shall be emptied and icable maintenance hoval of agent from halon ers shall only be done using ry systems. When the nee procedures are riodic recharging or ne 6-year requirement shall nguishers shall be subjected ervals of not more than 1 hydrostatic test, or when by an inspection or n. the following: one of survey) during the pproximately 8:45 AM, a the Assistant Maintenance Environmental Services rovide a copy of the facility s the various rooms. y provided layout identified tory building with a ately 9:22 AM on 05/18/2023 (19/2023 in the presence of tour of the building was	K 35		e need to in l areas of l that all pliance audits will monthly e	
	facility, the surveyor of twenty eight (28) port various locations that	observed and inspected table fire extinguishers in				

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PRINTED: 02/20/2024 FORM APPROVED

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,			(X3) DATE	
		315209	B. WING			06/	05/2023
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00,	
HAMMON	TON CENTER FOR REH	ABILITATION AND HEALTHCARE					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)			(EACH CORRECTIVE ACTION SHOULD E	3E	(X5) COMPLETION DATE
K 355	Continued From page	9 16	к	355			
	On 05/18/2023,		ERVICES OM ISUPPLENCLA TION NUMBER: A BUILDING 01 315209 B. WING TON NUMBER: ND HEALTHCARE ND HEALTHCARE INFORMATION) K 355 SURVEYOR Medical re extinguisher t Hydrostatic Surveyor r to the right of Type fire 1 2016. Surveyor r to the left of Type fire 1 2015. Surveyor r to the left of Type fire 1 2016. Surveyor r to the left of Type fire 1 2016. Surveyor r to the left of Type fire 1 2016. Surveyor r to the left of Type fire				
	observed in the baser supplies room, One '	9:38 AM, the surveyor ment near the Medical 'ABC" Type fire extinguisher olies room last Hydrostatic					
		ment commercial laundry be fire extinguisher last					
	,	-					
	observed on the seco	10:40 AM, the surveyor nd (2nd.) floor to the right of , One "ABC" Type fire rostatic tested 2016.					
	5) At approximately observed on the seco Nursing station, One extinguisher last Hydr	"ABC" Type fire					
	observed on the seco	11:29 AM, the surveyor nd (2nd.) floor to the left of 4 One "ABC" Type fire rostatic tested 2016.					
	observed on the seco	11:50 AM, the surveyor and (2nd.) floor to the left of 3 One "ABC" Type fire rostatic tested 2016.					

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM): 02/20/2024 APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		LE CONSTRUCTION 01		(X3) DATE	
		315209	B. WING				06/	05/2023
NAME OF PI	ROVIDER OR SUPPLIER	I			STREET ADDRESS, CITY, STATE, ZIP CODE	•		
HAMMON		ABILITATION AND HEALTHCARE			43 N WHITE HORSE PIKE			
					HAMMONTON, NJ 08037			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE		(X5) COMPLETION DATE
K 355	Continued From page	e 17	ĸ	355	5			
	8) At approximately	10:56 AM, the surveyor ond (2nd.) floor at the D- unit "ABC" Type fire						
	9) At approximately observed on the seco	12:01 PM, the surveyor ond (2nd.) floor at the One "ABC" Type fire						
	, ,							
	observed on the first	10:48 AM, the surveyor (1st.) floor to the left of , One "ABC" Type fire rostatic tested 2016.						
	observed on the first	7 10:55 AM, the surveyor (1st.) floor to the right of 3, One "ABC" Type fire rostatic tested 2016.						
	observed on the first	11:09 AM, the surveyor (1st.) floor in the corridor area, One "ABC" Type fire rostatic tested 2016.						
	observed on the first	11:33 AM, the surveyor (1st.) floor in the corridor ABC" Type fire extinguisher d 2015.						
	observed inside the k	212:01 PM, the surveyor Kitchen one Class K-Type Hydrostatic tested 2011.						

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		ID HUMAN SERVICES MEDICAID SERVICES			FOR	D: 02/20/202 MAPPROVE <u>0. 0938-039</u>
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING 01	CONSTRUCTION		E SURVEY PLETED
		315209	B. WING		06	/05/2023
NAME OF PF	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE	•	
HAMMON ⁻	TON CENTER FOR REH	ABILITATION AND HEALTHCARE	-	N WHITE HORSE PIKE AMMONTON, NJ 08037		
		ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECT		(25)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIOI DATE
K 355	Continued From page	e 18	K 355			
	This fire extinguisher damaged.	s metal cylinder was				
	observed on the first	12:10 PM, the surveyor (1st.) floor Dietary corridor, extinguisher last Hydrostatic				
		the finding at the time of				
		g the Life Safety Code imately 12:57 PM, the e Administrator of the				
	NFPA -10.					
	NJAC 8:39 -31.1 (c),	31.2 (e).				
K 364 SS=E	Corridor - Openings CFR(s): NFPA 101		K 364			6/22/23
	doors. Auxiliary space flammable or combust to have louvers or be In other than smoke of patient sleeping room are permitted in vision the openings per room inches and are at or b floor to ceiling. In spri per room do not excer Vision panels in corrie fixed window assemb	compartments containing ns, miscellaneous openings n panels or doors, provided m do not exceed 20 square below half the distance from inklered rooms, the openings eed 80 square inches. dor walls or doors shall be blies in approved frames. (In				
	÷ .	ke compartments, there are area and fire resistance of				

Facility ID: NJ60113

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		MEDICAID SERVICES			OMB NO. 093	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION 01	(X3) DATE SURVE COMPLETED	
		315209	B. WING		06/05/20	23
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
HAMMON	TON CENTER FOR REH	ABILITATION AND HEALTHCARE		43 N WHITE HORSE PIKE HAMMONTON, NJ 08037		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMP	(X5) PLETIO DATE
K 364	Continued From page	e 19	K 364	4		
	by: Based on observatio provided documentat presence of facility m determined that the fa transfer grills in corric sleeping units. This deficient practice following: On 05/18/2023 (day of survey entrance at ap request was made to Manager (AMM) and Director (EVSD) to pr layout which identifies A review of the facility the facility is a two-ste first floor, 60 resident second floor and varie floors. Starting at approxima in the presence of the was conducted. At 12:12 PM, the surv 19 inch open transfer wall.	is not met as evidenced ins and review of facility ion on 05/18/2023, in the anagement, it was acility failed to prohibit for walls on resident e was evidenced by the one of survey) during the oproximately 8:45 AM, a the Assistant Maintenance Environmental Services rovide a copy of the facility is the various rooms. y provided layout identified ory building and a basement. sident sleeping rooms on the ous common areas on both ately 9:22 AM on 05/18/2023 a AMM a tour of the building yeyor observed a 19 inch by ingrill installed in the corridor		 Facility ordered a new motorized smoke/fire damper to be installed or second floor HVAC activities closet the elevator. All other areas of the fa have been checked and audited to a no other areas need a smoke/fire da There were no other areas identified need of smoke/fire damper as a res this audit. All residents can be affected by th deficient practice. Dir of Maintenand all Maintenance personnel have bee serviced on NFPA 101 related to the requirement on that all Transfer grill installed in walls need to be equipped a smoke/fire damper. Dir of Maintenance will audit all a facility monthly x 3 months or until compliance is reached to ensure tha areas of the facility that have a trans grill installed in the wall have a smot damper installed as well to prevent spread of smoke/fire. All the Maintenance Directors aud be presented during the facilities mod QAPI meeting. All concerns will be discussed and addressed immediated 	n the near acility ensure amper. d in ult of nis e and en in e s ed with reas of at all sfer ke/fire the dits will onthly	
	lead into an Activities a Heating, Ventilation	entified the open transfer grill storage room which housed and Air Conditioning a open closet with-in the				

Facility ID: NJ60113

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 02/20/20 FORM APPROVE OMB NO. 0938-039
TATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING 0	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		315209	B. WING		06/05/2023
	ROVIDER OR SUPPLIER	ABILITATION AND HEALTHCARE	4:	TREET ADDRESS, CITY, STATE, ZIP CODE 3 N WHITE HORSE PIKE AMMONTON, NJ 08037	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETIO
K 364	storage room multiple The AMM confirmed day tour of the facility inspections. On 05/19/2023 during survey exit at approx	urveyor observed inside the e combustible items. the findings during the two	K 364		
K 372 SS=E	CFR(s): NFPA 101 Subdivision of Buildir Construction 2012 EXISTING Smoke barriers shall fire resistance rating be permitted to termi Smoke dampers are penetrations in fully of an approved sprinkle smoke compartments barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechan in REMARKS. This REQUIREMENT by: Based on observation	ng Spaces - Smoke Barrie ng Spaces - Smoke Barrier be constructed to a 1/2-hour per 8.5. Smoke barriers shall nate at an atrium wall. not required in duct ducted HVAC systems where r system is installed for s adjacent to the smoke nical smoke control system Γ is not met as evidenced ons and review of facility	К 372	1. On 5/22 the Maintenance Departm	
	05/19/2023 in the pre management, it was failed to maintain the	tion on 05/18/2023 and esence of facility determined that the facility integrity of smoke barrier of ten (10) smoke barrier		sealed the penatration noted in the wa 2nd floor A wing above double doors. 5/23 the penatration in the wall on D v above the corridor double doors was sealed with fire rated sealer in accord	On ving

Event ID: Q82921

Facility ID: NJ60113

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		MEDICAID SERVICES					D. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING		CONSTRUCTION	· · ·	E SURVEY PLETED
		315209	B. WING			06	/05/2023
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
HAMMON	TON CENTER FOR REH	ABILITATION AND HEALTHCARE			N WHITE HORSE PIKE AMMONTON, NJ 08037		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETIC DATE
K 372	Continued From page	e 21	K 37	72			
	walls as evidenced by	y the following:			with NFPA 101. All other areas in the		
		•			facility have been audited to ensure th		
	· · ·	one of survey) during the oproximately 8:45 AM, a			there are no gaps in need of fire-resis material. There have been no other a		
		the Assistant Maintenance			in need of fire-resistant seal as a resu		
	Manager (AMM) and	Environmental Services			this audit.		
		ovide a copy of the facility's			2. All residents can be affected by this		
	layout which identifies	s the various rooms.			deficient practice. Dir of Maintenance all Maintenance personnel have been		
	A review of the facility	/ provided layout identified			serviced on NFPA 101 related to smol		
		ory building and a basement.			barrier construction with specificity to		
		oke barrier walls on the			openings and penetrations that require	e	
	the first floor.	(6) smoke barrier walls on			NFPA approved fire rated seal. 3. Dir of Maintenance will audit all are	as of	
					facility weekly x 4 weeks and then mo	nthly	
		ately 9:22 AM on 05/18/2023			x 3 months or until compliance is reac		
		19/2023 in the presence of our of the building was			to ensure that all areas of the facility the require NFPA approved fire resistance		
	conducted.				seal have been corrected.		
					4. All the Maintenance Directors audit		
		ur, the surveyor observed the			be presented during the facilities mon	thly	
	following smoke barri maintain the 1/2 hour	fire rated construction as			QAPI meeting. All concerns will be discussed and addressed immediately	,	
	required by code in th						
	On 05/18/2023,						
	1) At approximately	10:35 AM, the surveyor					
		corridor double smoke doors					
		the second floor "A-Wing",					
		penetration with a electrical h the smoke barrier wall.					
	,	11:35 AM, the surveyor					
		corridor double smoke doors					
		the second floor "D-Wing", 1/2" penetration with a white					
	electrical cable and o						
	through the smoke ba						

ON (X3) DATE SURVEY COMPLETED
SS, CITY, STATE, ZIP CODE
DRSE PIKE
N, NJ 08037
PROVIDER'S PLAN OF CORRECTION (X5) ACH CORRECTIVE ACTION SHOULD BE SS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
6/22/23
n 5/2

Event ID: Q82921

Facility ID: NJ60113

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	S FOR MEDICARE &						NO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING		ONSTRUCTION	· · ·	ATE SURVEY OMPLETED
		315209	B. WING				06/05/2023
NAME OF P	ROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE		
HAMMON	TON CENTER FOR REH	ABILITATION AND HEALTHCARE			N WHITE HORSE PIKE MMONTON, NJ 08037		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIO DATE
K 374	Continued From page	e 23	К 37	74			
	failed to maintain smo the transfer of smoke fire protection. This of identified for 4 of 10 s barrier doors tested a following: Reference 1: Life Safety Code 101 - 8.5.4.1, Doors in sr opening, leaving only necessary for proper without louvers or gri bottom of a new door of an inch. On 05/18/2023 (day of survey entrance at ap request was made to Manager (AMM) and Director (EVSD) to pr layout which identified	eets of corridor smoke and was evidenced by the , 2012 Edition, noke barriers shall close the the minimum clearance operation, and shall be ils. The clearance under the shall be a maximum of 3/4 one of survey) during the oproximately 8:45 AM, a the Assistant Maintenance Environmental Services rovide a copy of the facility			a metal plate door sweep to the 2nd A wing double doors, C wing double doors, 2nd floor D wing double doors 1st floor C wing double doors. All mentioned doors are now at 3/4 inch the floor level. All other smoke barrie doors have been checked and audite ensure that there are no gaps measu more than 3/4 of an inch high off the level. 2. All residents can be affected by th deficient practice. Dir of Maintenance all Maintenance personnel have been serviced on NFPA 101 related to smo barrier doors and the requirement to ensure that there are no gaps measu more than 3/4 of an inch high off the level in accordance with NFPA 101. 3. Dir of Maintenance will audit all sm barrier doors of facility weekly x 4 we and then monthly x 3 months or until compliance is reached to ensure that smoke barrier doors have no gaps measuring more than 3/4 of an inch fit the floor to the bottom of the door. 4. All the Maintenance Directors aud	and off r d to ring floor s and o in oke ring floor noke eks c all	
	and second floors. Starting at approxima and continued on 05/ the facility's AMM a to conducted. Along the surveyor performed a	or smoke doors on the first ately 9:22 AM on 05/18/2023 19/2023 in the presence of our of the building was two (2) day tour the a closure test of ten (10) sets rs in the corridors with the			be presented during the facilities mon QAPI meeting. All concerns will be discussed and addressed immediate		

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		ID HUMAN SERVICES MEDICAID SERVICES			FORM AP OMB NO. 09	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION 01	(X3) DATE SUR COMPLETE	
		315209	B. WING		06/05/2	023
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
HAMMON	TON CENTER FOR REH	ABILITATION AND HEALTHCARE		43 N WHITE HORSE PIKE		
				HAMMONTON, NJ 08037		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE CC	(X5) MPLETION DATE
K 374	Continued From page	e 24	K 374	ı		
	 1) At approximately 10:35 AM, during a closure test of the 2nd. floor "A- Wing" double smoke doors in the corridor next to Resident room #A-201, when the doors were released from the magnetic hold open device and allowed to self close into their frame, the surveyor observed and measured a 1-1/8 inch wide by 8 inch high gap along the bottom meeting edge of the doors. This test was repeated two additional times with the same results. 2) At approximately 11:22 AM, during a closure test of the 2nd. floor "C- Wing" double smoke doors in the corridor next to Resident room #C-202, when the doors were released from the magnetic hold open device and allowed to self close into their frame, the surveyor observed and measured a 1-1/8 inch undercut gap along the bottom edge of the doors. 					
	This test was repeate the same results.	ed two additional times with				
	test of the 2nd. floor ' doors in the corridor i #D-201, when the do magnetic hold open of close into their frame measured a 1/4 inch	11:44 AM, during a closure 'D- Wing" double smoke next to Resident room ors were released from the device and allowed to self , the surveyor observed and wide by 7 inch high gap eting edge of the doors.				
	This test was repeate the same results.	ed two additional times with				
		transfer of smoke, fire, and pass from one smoke				

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If continuation sheet Page 25 of 31

TATEMENT ((X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DA	NO. 0938-039 TE SURVEY MPLETED
		A. BUILDING 01				
		315209	B. WING		0	6/05/2023
NAME OF P	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
HAMMON	TON CENTER FOR REH	ABILITATION AND HEALTHCARE	43	N WHITE HORSE PIKE		
			H	AMMONTON, NJ 08037		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
K 374	Continued From page	e 25	K 374			
		ner in the event of a fire.	_			
	On 05/19/2023,					
	test of the 1st. floor "G doors in the corridor if when the doors were hold open device and their frame, the surve a 1-1/8 inch undercut of the doors. This test was repeate the same results. This would allow the poisonous gasses to compartment to anoth The AMM confirmed if day tour of the facility inspections.					
	survey exit at approxi surveyor informed the deficiency.					
K 521 SS=E	N.B. 8:39-31.1(c), 31 HVAC CFR(s): NFPA 101	.2(e)	K 521			6/22/23
	HVAC Heating, ventilation, a comply with 9.2 and s accordance with the specifications.					

Event ID: Q82921

Facility ID: NJ60113

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		ND HUMAN SERVICES MEDICAID SERVICES			OMB NO.	APPROVE 0938-039
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	LE CONSTRUCTION 01	(X3) DATE S COMPL		
		315209	B. WING		06/0	5/2023
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	• • • •	
				43 N WHITE HORSE PIKE		
HAMMON	TON CENTER FOR REH	ABILITATION AND HEALTHCARE		HAMMONTON, NJ 08037		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
K 521	Continued From page	e 26	K 52	1		
1021	18.5.2.1, 19.5.2.1, 9.		K 52	1		
	10.3.2.1, 19.3.2.1, 9.	2				
	This REQUIREMENT	Γ is not met as evidenced				
	Based on observation	ons on 05/18/2023 and		1. Exhaust fans in rooms B110	and	
	05/19/2023 in the pre			B111-bathroom, resident bathro		
	-	determined that the facility		were corrected on 5/22/23. Exl		
		the facility's ventilation		in resident bathroom D108 and		
		properly maintained for 5 of		bathroom in D 112 have all bee		
		m exhaust systems as per tection Association (NFPA)		corrected on 5/23/23 and are no working condition. All other exh		
	90A.			in resident rooms and bathroon		
	00/1			been checked and audited to en		
	This deficient practic	e was evidenced by the		they are in good working order.		
	following:	-		concerns were noted with any o		
				exhaust fans as a result of this		
		one of survey) during the		2. All residents can be affected	-	
		pproximately 8:45 AM, a		deficient practice. Dir of Mainte		
	· ·	the Assistant Maintenance		all Maintenance personnel have		
		Environmental Services		serviced on NFPA 101 related t		
		rovide a copy of the facility s the various rooms and		ventilation and the requirement exhaust fans to be in good worl		
	smoke compartments			condition.	wig	
				3. Dir of Maintenance will audit	all exhaust	
	A review of the facilit	y provided layout identified		fans of facility weekly x 4 weeks		
		tory building with 120		monthly x 3 months or until con		
	Resident sleeping roo	oms and various common		reached to ensure that all exha		
	areas.			are in good working condition a		
				providing the various areas of the	he facility	
		ately 9:22 AM on 05/18/2023		with proper ventilation.		
	and continued on 05	19/2023 in the presence of		4. All the Maintenance Director		
		and af the a face life and a				
	the facility's AMM a te			be presented during the facilitie		
	the facility's AMM a to conducted. Along the	e two (2) day tour the		QAPI meeting. All concerns will	be	
	the facility's AMM a to conducted. Along the surveyor inspected a				be	

Facility ID: NJ60113

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN		(X3) DATE SURVEY COMPLETED		
		315209	B. WING			06/	05/2023
NAME OF P	ROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
HAMMON	TON CENTER FOR REH	ABILITATION AND HEALTHCARE			WHITE HORSE PIKE MONTON, NJ 08037		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)				PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
K 521	Continued From page	27	K 5	21			
	Continued From page 27 This inspection identified when the bathroom exhaust systems were tested (by placing a piece of single ply tissue paper across the grills to confirm ventilation is present), the exhaust did not function properly in 4 of 14 resident bathrooms in the following locations: On 05/19/2023, 1. At approximately 10:40 AM, inside Resident room #B-110 bathroom, when tested the exhaust system did not function properly. At this time, the surveyor informed the AMM that the exhaust system did not function properly. This bathroom had no window with an area that would open. This bathroom would rely on mechanical ventilation. 2. At approximately 10:45 AM, inside Resident room #B-111 bathroom, when tested the exhaust system did not function properly. This bathroom had no window with an area that would open. This bathroom would rely on mechanical ventilation. 3. At approximately 10:47 AM, inside Resident room #B-113 bathroom, when tested the exhaust system did not function properly. This bathroom had no window with an area that would open.						
	This bathroom would ventilation.	rely on mechanical					
	4. At approximately 1	11:21 AM, inside Resident					

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				FC	ED: 02/20/2024 RM APPROVED NO. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		· · ·			TE SURVEY MPLETED
	315209	B. WING _			06/05/2023
ROVIDER OR SUPPLIER	l		STREET ADDRESS, CITY, STAT		
	ABILITATION AND HEALTHCARE		43 N WHITE HORSE PIKE		
TON DENTER TOR REIN			HAMMONTON, NJ 08037		
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	((EACH CORRECT CROSS-REFERENC	TIVE ACTION SHOULD BE CED TO THE APPROPRIATE	(X5) COMPLETION DATE
room #D-108 bathroo system did not functio had no window with a This bathroom would ventilation. 5. At approximately room #D-112 bathroo system did not functio had no window with a This bathroom would ventilation. The AMM confirmed to observations. On 05/19/2023 during survey exit at approximately	om, when tested the exhaust on properly. This bathroom an area that would open. rely on mechanical 11:23 AM, inside Resident on properly. This bathroom an area that would open. rely on mechanical the findings at the time of g the Life Safety Code imately 12:57 PM, the	K	521		
NJAC 8:39- 31.2 (e). Electrical Systems - E	Essential Electric Syste	КS	018		6/22/23
Maintenance and Tes The generator or oth and associated equip service within 10 sec criterion is not met du process shall be prov capability for the life s	ting er alternate power source ment is capable of supplying onds. If the 10-second uring the monthly test, a ided to annually confirm this safety and critical branches.				
	S FOR MEDICARE & DF DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER TON CENTER FOR REHA SUMMARY ST. (EACH DEFICIENC REGULATORY OR I Continued From page room #D-108 bathrood system did not function had no window with a This bathroom would ventilation. 5. At approximately from #D-112 bathrood system did not function had no window with a This bathroom would ventilation. 5. At approximately from #D-112 bathrood system did not function had no window with a This bathroom would ventilation. The AMM confirmed from observations. On 05/19/2023 during survey exit at approxi surveyor informed the deficiency. NFPA 90A. NJAC 8:39- 31.2 (e). Electrical Systems - E Maintenance and Tes The generator or oth and associated equip service within 10 secu- criterion is not met du process shall be prov- capability for the life s	CORRECTION IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: 315209 ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 28 room #D-108 bathroom, when tested the exhaust system did not function properly. This bathroom had no window with an area that would open. This bathroom would rely on mechanical ventilation. 5. At approximately 11:23 AM, inside Resident room #D-112 bathroom, when tested the exhaust system did not function properly. This bathroom had no window with an area that would open. This bathroom would rely on mechanical ventilation. 5. At approximately 11:23 AM, inside Resident room #D-112 bathroom, when tested the exhaust system did not function properly. This bathroom had no window with an area that would open. This bathroom would rely on mechanical ventilation. The AMM confirmed the findings at the time of observations. On 05/19/2023 during the Life Safety Code survey exit at approximately 12:57 PM, the surveyor informed the Administrator of the deficiency. NFPA 90A. NJAC 8:39- 31.2 (e). Electrical Systems - Essential Electric System	SPOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIEN/CLA IDENTIFICATION NUMBER: (X2) MULT A. BUILDIN STORRECTION (X1) PROVIDER/SUPPLIEN/CLA IDENTIFICATION NUMBER: (X2) MULT A. BUILDIN SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREEPO TAG Continued From page 28 room #D-108 bathroom, when tested the exhaust system did not function properly. This bathroom had no window with an area that would open. K 5 This bathroom would rely on mechanical ventilation. 5. At approximately 11:23 AM, inside Resident room #D-112 bathroom, when tested the exhaust system did not function properly. This bathroom had no window with an area that would open. This bathroom would rely on mechanical ventilation. The AMM confirmed the findings at the time of observations. On 05/19/2023 during the Life Safety Code survey exit at approximately 12:57 PM, the surveyor informed the Administrator of the deficiency. K 5 NFPA 90A. NJAC 8:39- 31.2 (e). Electrical Systems - Essential Electric System Grees or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches.	SPOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES (X1) PROVIDER/SUPPLIENCLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BUILDING 01 STREET ADDRESS, CITY, STA 315209 STREET ADDRESS, CITY, STA 43 N WHTE HORSE PIKE SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WILL REGULATORY OR LSC IDENTIFYING INFORMATION) 0 PROVIDERS 7 (EACH DEFICIENCY WILL REGULATORY OR LSC IDENTIFYING INFORMATION) 0 PROVIDERS 7 (EACH DEFICIENCY WILL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 28 room #D-108 bathroom, when tested the exhaust system did not function properly. This bathroom had no window with an area that would open. K 521 This bathroom would rely on mechanical ventilation. K 521 5. At approximately 11:23 AM, inside Resident room #D-112 bathroom, when tested the exhaust system did not function properly. This bathroom had no window with an area that would open. This bathroom would rely on mechanical ventilation. 0 The AMM confirmed the findings at the time of observations. On 05/19/2023 during the Life Safety Code survey exit at approximately 12:57 PM, the surveyor informed the Administrator of the deficiency. K 918 FIEACIAL Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 second. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. <td>MENT OF HEALTH AND HUMAN SERVICES PO SEFOR MEDICARE & MEDICALO SERVICES OMB I POPERCENCIES (X1) PROVIDENSIPPLERCIA LIDENTIFICATION NUMBER: 315209 B. WING COMPACT ADDRESS, CITY, STATE, JP CODE 4 NUMPTE HORSE PIKE HAMMONTON, NJ 08037 PROVIDER OR SUPPLIER TON CENTER FOR REHABILITATION AND HEALTHCARE SUMMARY STATEMENT OF DEPICIENCIES (RCAT DEPICIENCY OR LSC DENTIFYING INFORMATION) REGULATORY OR LSC DENTIFYING INFORMATION) Continued From page 28 room 4D-108 bathroom, when tested the exhaust system did not function properly. This bathroom had no window with an area that would open. This bathroom would rely on mechanical ventilation. 5. At approximately 11:23 AM, inside Resident room 4D-112 bathroom, when tested the exhaust system did not function properly. This bathroom had no window with an area that would open. This bathroom would rely on mechanical ventilation. The bathroom would rely on mechanical ventilation. The AMM confirmed the findings at the time of observations. On 05/19/2023 during the Life Safety Code survey rind romed the Administrator of the deficiency. NFPA 90A NUAC 8:39-312 (e). Electrical Systems - Essential Electric System Maintenance and Testing The generator or other altemate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second oriterion is not met during the original power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second oriterion is not met during the original power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second oriterion is not met during the original power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second oriterion is not met during the original power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second oriterion is not met during the original power source and associated equipment is capable</td>	MENT OF HEALTH AND HUMAN SERVICES PO SEFOR MEDICARE & MEDICALO SERVICES OMB I POPERCENCIES (X1) PROVIDENSIPPLERCIA LIDENTIFICATION NUMBER: 315209 B. WING COMPACT ADDRESS, CITY, STATE, JP CODE 4 NUMPTE HORSE PIKE HAMMONTON, NJ 08037 PROVIDER OR SUPPLIER TON CENTER FOR REHABILITATION AND HEALTHCARE SUMMARY STATEMENT OF DEPICIENCIES (RCAT DEPICIENCY OR LSC DENTIFYING INFORMATION) REGULATORY OR LSC DENTIFYING INFORMATION) Continued From page 28 room 4D-108 bathroom, when tested the exhaust system did not function properly. This bathroom had no window with an area that would open. This bathroom would rely on mechanical ventilation. 5. At approximately 11:23 AM, inside Resident room 4D-112 bathroom, when tested the exhaust system did not function properly. This bathroom had no window with an area that would open. This bathroom would rely on mechanical ventilation. The bathroom would rely on mechanical ventilation. The AMM confirmed the findings at the time of observations. On 05/19/2023 during the Life Safety Code survey rind romed the Administrator of the deficiency. NFPA 90A NUAC 8:39-312 (e). Electrical Systems - Essential Electric System Maintenance and Testing The generator or other altemate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second oriterion is not met during the original power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second oriterion is not met during the original power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second oriterion is not met during the original power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second oriterion is not met during the original power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second oriterion is not met during the original power source and associated equipment is capable

Facility ID: NJ60113

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		ND HUMAN SERVICES			FOF	ED: 02/20/202 RM APPROVE
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01			IO. 0938-039 TE SURVEY MPLETED	
		315209	B. WING		0	6/05/2023
	ROVIDER OR SUPPLIER	ABILITATION AND HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP C 43 N WHITE HORSE PIKE		
				HAMMONTON, NJ 08037		
(X4) ID PREFIX TAG	(EACH DEFICIENC	IATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
K 918	Continued From page	e 29	К 9	18		
	transfer switches are					
	 transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 			1. The facility contacted its	sgenerator	
	the facility managem the facility failed to en- station for 1 of 1 eme installed in accordance NFPA 110, 2010 Edit 5.6.5.6.1.	9/2023 in the presence of ent, it was determined that nsure a remote manual stop ergency generators was ce with the requirements of ion, Section 5.6.5.6 and		service vendor for them to emergency stop button. Ge and facility will schedule a to install the required Emer button. Facility has only on 2. All residents can be affer deficient practice. Dir of Ma all Maintenance personnel	install a remote enerator vendor date for service rgency stop e generator. cted by this aintenance and have been in	
	The deficient practice following:	e was evidenced by the		serviced on NFPA 101 rela requirement of facility gene an Emergency stop Button	rators to have	

Facility ID: NJ60113

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						10.0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION G 01	· · ·	TE SURVEY MPLETED
	315209		B. WING		0	6/05/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	
HAMMON	TON CENTER FOR REH	ABILITATION AND HEALTHCARE		43 N WHITE HORSE PIKE HAMMONTON, NJ 08037		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
 K 918 Continued From page 30 On 05/18/2023 (day one of survey) during the survey entrance at approximately 8:45 AM, a request was made to the Assistant Maintenance Manager (AMM) and Environmental Services Director (EVSD) if the facility had an Emergency Generator. The AMM told the surveyor, yes we have one Diesel Emergency Generator. On 05/18/2023 (day one of survey) at approximately 10:06 AM, in the presence of the AMM, an inspection inside the boiler room when the Emergency Generator is located, the survey observed that the emergency stop button was located on the front control panel of the generator. At this time the surveyor asked the AMM, "Do yo have a remote emergency stop button for the generator." The AMM said, no. 		one of survey) during the oproximately 8:45 AM, a the Assistant Maintenance Environmental Services e facility had an Emergency rveyor, yes we have one enerator. one of survey) at AM, in the presence of the nside the boiler room where erator is located, the surveyor tergency stop button was iontrol panel of the yor asked the AMM, "Do you gency stop button for the	К 9	18 good working condition. 3. Dir of Maintenance will au generator weekly x 4 weeks monthly x 3 months or until of reached to ensure that the E stop button is in good workin 4. All the Maintenance Direct be presented during the faci QAPI meeting. All concerns discussed and addressed im	and then compliance is mergency ng condition. tors audits will lities monthly will be	
	the Administrator of the NJAC 8:39-31.2(e), 3	PM, the surveyor informed he deficiency.				

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POST-CERTIFICATION REVISIT REPORT

	MULTIPLE CONSTRUCTION A. Building 01 - MAIN BUIL DING 01		DATE OF REVISIT	
	A. Building 01 - MAIN BUILDING 01 B. Wing	Y2	8/1/2023	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE		
HAMMONTON CENTER FOR REF	ABILITATION AND HEALTHCARE	43 N WHITE HORSE PIKE		
		HAMMONTON, NJ 08037		

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITE	м	DATE	ITEM			DATE	ITEM			DATE
Y4		Y5	Y4			Y5	Y4			Y5
ID Prefix		Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #	NFPA 101	Completed	Reg. #	NFPA 1	01	Completed	Reg. #	NFPA 101		Completed
LSC	K0222	06/22/2023	LSC	K0311		06/22/2023	LSC	K0321		06/22/2023
ID Prefix		Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #	NFPA 101	Completed	Reg. #	NFPA 1	01	Completed	Reg. #	NFPA 101		Completed
LSC	K0341	06/22/2023	LSC	K0351		06/22/2023	LSC	K0355		06/22/2023
ID Prefix		Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #	NFPA 101	Completed	Reg. #	NFPA 1	01	Completed	Reg. #	NFPA 101		Completed
LSC	K0364	06/22/2023	LSC	K0372		06/22/2023	LSC	K0374		06/22/2023
ID Prefix		Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #	NFPA 101	Completed	Reg. #	NFPA 1	01	Completed	Reg. #			Completed
LSC	K0521	06/22/2023	LSC	K0918		06/22/2023	LSC			
ID Prefix		Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #		Completed	Reg. #			Completed	Reg. #			Completed
LSC			LSC				LSC			
REVIEWE STATE AC		REVIEWED BY (INITIALS)	DATE		SIGNATURE	OF SURVEYOR			DATE	
REVIEWE CMS RO	D BY	REVIEWED BY (INITIALS)	DATE		TITLE				DATE	
FOLLOWUP TO SURVEY COMPLETED ON 6/5/2023					RECTED DEFICIENCIES NCIES (CMS-2567) SEN					
Form CMS	S - 2567B (09/92)	EF (11/06)	-		Page 1 of 1			EVENT ID:	Q82922	