| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315209 | A. BUILDING **01**<br>B. WING _____ | **06/05/2023** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **HAMMONTON CENTER FOR REHABILITATION AND HEALTHCARE** | **43 N WHITE HORSE PIKE**<br>**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 |
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| K 000 | INITIAL COMMENTS<br><br>A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 05/18/2023 and 05/19/2023 and Hammonton Center For Rehabilitation and Healthcare 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 Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies.<br><br>Hammonton Center For Rehabilitation and Healthcare is a Two-story, Type I Fire Resistant building that was built in January 1984. The facility is divided into 13 smoke zones. The facility has one Diesel emergency generator. | K 000 | | |
| K 222 SS=E | Egress Doors<br>CFR(s): NFPA 101<br><br>Egress Doors<br>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:<br>CLINICAL NEEDS OR SECURITY THREAT LOCKING<br>Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the 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.<br>18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 | K 222 | | 6/22/23 |

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

Electronically Signed | 06/22/2023

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| K 222 | Continued From page 1<br>SPECIAL NEEDS LOCKING ARRANGEMENTS<br>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.<br>18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4<br>DELAYED-EGRESS LOCKING ARRANGEMENTS<br>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.<br>18.2.2.2.4, 19.2.2.2.4<br>ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS<br>Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted.<br>18.2.2.2.4, 19.2.2.2.4<br>ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS<br>Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised | K 222 | | |

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| K 222 | Continued From page 2<br>automatic sprinkler system.<br>18.2.2.2.4, 19.2.2.2.4<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and review of facility provided documentation on 05/18/2023 and 05/19/2023, it was determined that the facility failed to provide 1 of 11 designated exit discharge doors in the means of egress readily accessible and free of all obstructions or impediments to full instant use in the case of fire or other emergencies in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.2.2.2.5.1, 19.2.2.2.5.2 and 19.2.2.2.6.<br><br>Findings include:<br><br>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.<br><br>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.<br><br>Starting at approximately 9:22 AM on 05/18/2023 and continued on 05/19/2023 in the presence of the facility AMM a tour of the building was conducted.<br><br>During the two (2) day building tour the of the facility the surveyor inspected eleven (11) designated exit discharge doors with the following | K 222 | 1. Facility removed the knob latches from the front entrance doors. All other Egress Doors of the facility have been audited. No Additional knob latches have been discovered as a result of this audit.<br>2. All resident can be affected by this deficient practice. Dir. of Maintenance and all Maintenance personal have been in serviced on NFPA 101 related to egress with specificity on the requirement that knob latches cannot be install on any doors used for means of Egress.<br>3. Dir of Maintenance will audit all areas of facility weekly x 4 weeks and then monthly x 3 months or until compliance is reached to ensure that no latches have been installed on any doors used for means of Egress .<br>4. All the Maintenance Directors audits will be presented during the facilities monthly QAPI meeting. All concerns will be discussed and addressed immediately. | |

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| K 222 | Continued From page 3<br>results:<br><br>1) On 05/19/2023 at approximately 11:48 AM, the surveyor observed the main entrance two sets of automatic sliding exit discharge doors (internal set of doors and external set of doors) revealed thumb turn locks on the egress side of both sets of doors. The thumb turn lock and fastening device on the door could restrict emergency use of the exit.<br><br>The doors had a sign that read, Push here in the event of an emergency.<br>Thumb turn locks and fastening device on the door could restrict emergency use of the exit.<br><br>The AMM confirmed the findings at the times of observations.<br><br>On 05/19/2023 during the survey exit at approximately 12:57 PM, the surveyor informed the Administrator of the deficiency.<br><br>NJAC 8:39 -31.2 (e) | K 222 | | |
| K 311 SS=D | NFPA 101 2012 - 7.2.1.6.1 (4).<br>Vertical Openings - Enclosure<br>CFR(s): NFPA 101<br><br>Vertical Openings - Enclosure<br>2012 EXISTING<br>Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6<br>If all vertical openings are properly enclosed with | K 311 | | 6/22/23 |

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| K 311 | Continued From page 4<br>construction providing at least a 2-hour fire resistance rating, also check this box.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and review of facility documentation on 05/18/2023 and 05/19/2023, in the presence of facility Management it was determined that the facility failed to ensure that 1 of 14 exit access stairwell doors tested, were capable of maintaining the 1-1/2 hour fire rated construction.<br><br>This is evidenced by the following,<br><br>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.<br><br>A review of the facility provided lay-out identified the facility is a two-story building and a basement with fourteen (14) designated exit access doors (illuminated exit signs above doors) that Resident, Staff and Visitors would use in the event of an emergency to exit the building.<br><br>Starting at approximately 9:22 AM on 05/18/2023 and continued on 05/19/2023 in the presence of the facility AMM a tour of the building was conducted.<br><br>During the two (2) day building tour the of the facility the surveyor inspected and conducted closure test of fourteen (14) exit access doors leading into exit stairways with the following results: | K 311 | 1. On 5/18/2023 Maintenance Department immediately addressed and fixed the existing door knob to positively latch upon closure of the door. All other doors used for means of Egress that have doorknobs installed on them, have been audited to ensure that they positively latch upon closure of the door. No additional issues have been discovered as a result of this audit.<br>2. All residents can be affected by this deficient practice. Dir of Maintenance and all Maintenance personnel have been in serviced on NFPA 101 related to vertical openings with specificity on doors positively latching for all exit access doors.<br>3. Dir of Maintenance will audit all areas of facility weekly x 4 weeks and then monthly x 3 months or until compliance is reached to ensure that all exit doors positively latch upon closure.<br>4. All the Maintenance Directors audits will be presented during the facilities monthly QAPI meeting. All concerns will be discussed and addressed immediately. | |

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| K 311 | Continued From page 5<br><br>On 05/19/2023,<br><br>1. At approximately 11:33 AM, during a closure test of the first (1st.) floor stairway (next to Social Services) corridor exit access door, when the door was opened to a 90 degree opening to the door frame and allowed to self-close, the door did not positive latch into its frame.<br><br>This test was performed two additional times with the same results.<br>The surveyor observed the door had no means to positive latch into its frame.<br><br>The stairwell doors would need to positive latch into its frame to maintain the 1-1/2 hour fire rated construction to prevent fire, smoke and poisonous gases to enter the exit stairwell in the event of a fire.<br><br>The AMM confirmed the finding at the time of observations.<br><br>On 05/19/2023 during the Life Safety Code survey exit at approximately 12:57 PM, the surveyor informed the Administrator of the deficiency.<br><br>Fire Safety Hazard. | K 311 | | |
| K 321 SS=E | NJAC 8:39- 31.2(e)<br>Hazardous Areas - Enclosure<br>CFR(s): NFPA 101<br><br>Hazardous Areas - Enclosure<br>Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour | K 321 | | 6/22/23 |

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| K 321 | Continued From page 6<br>fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door.<br>Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.<br>19.3.2.1, 19.3.5.9<br><br>Area Automatic Sprinkler Separation N/A<br>a. Boiler and Fuel-Fired Heater Rooms<br>b. Laundries (larger than 100 square feet)<br>c. Repair, Maintenance, and Paint Shops<br>d. Soiled Linen Rooms (exceeding 64 gallons)<br>e. Trash Collection Rooms (exceeding 64 gallons)<br>f. Combustible Storage Rooms/Spaces (over 50 square feet)<br>g. Laboratories (if classified as Severe Hazard - see K322)<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and review of facility documentation on 05/18/2023 and 05/19/2023 in the presence of facility management, it was determined that the facility failed to ensure that fire-rated doors to hazardous areas were self-closing, and were separated by smoke resisting partitions in accordance with NFPA 101, 2012 Edition, Section 19.3.2.1, 19.3.2.1.3, 19.3.2.1.5, 19.3.6.3.5, 19.3.6.4, 8.3, 8.3.5.1, 8.4, 8.5.6.2 and 8.7. | K 321 | 1. The Maintenance department adjusted the Dietary dry storage door and the Medical Records storage room door to ensure that these doors self-close into their frame upon closure.<br>2. All residents can be affected by this deficient practice. Dir. of Maintenance and all Maintenance personal have been in serviced on NFPA 101 related to Hazardous areas  enclosures to ensure that all self-closing doors self-close into | |

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| K 321 | Continued From page 7<br>This deficient practiced was evidenced by the following:<br><br>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.<br><br>A review of the facility provided lay-out identified the facility is a two-story building and a basement.<br><br>Starting at approximately 9:22 AM on 05/18/2023 in the presence of the facility AMM a tour of the building was conducted.<br><br>Along the tour of the facility the surveyor observed the following hazardous area that failed to have smoke resisting doors.<br><br>On 05/18/2023:<br><br>1) At approximately 9:39 AM, an inspection of the Medical records storage room in the basement was performed.<br><br>During a closure test of the corridor door leading into the Medical records storage room, the door did not self-close into its frame. The surveyor observed 22 combustible boxes of medical records in the room.<br><br>This test was repeated two additional times with the same results.<br><br>The room was larger than 50 square feet.<br><br>With this corridor door not self-closing this would | K 321 | their frames upon closure.<br>3. Dir of Maintenance will audit all areas of facility weekly x 4 weeks and then monthly x 3 months or until compliance is reached to ensure that all doors fit into their frames upon closure.<br>4. All the Maintenance Directors audits will be presented during the facilities monthly QAPI meeting. All concerns will be discussed and addressed immediately | |

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| K 321 | Continued From page 8<br>allow fire, smoke and poisonous gases to pass into the exit access corridor in the event of a fire.<br><br>2) At approximately 10:03 AM, an inspection of the Dietary storage room in the basement was performed.<br><br>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.<br><br>This closure test was repeated two additional times with the same results.<br><br>The surveyor observed and recorded measurements of the opening of the door to the frame was a 1/2 inch gap between the door and frame.<br><br>The surveyor measured and recorded the room which is 14 feet by 21 feet (294 square feet) which is larger than 50 square feet.<br><br>With this corridor door not self-closing this would allow fire, smoke and poisonous gases to pass into the exit access corridor in the event of a fire.<br><br>A review of an emergency evacuation diagram posted on the corridor wall in the area identified that you would need to pass these rooms as the primary and or secondary egress route out of the area in the event of a fire.<br><br>The AMM confirmed the findings at the time.<br><br>On 05/19/2023 during the Life Safety Code survey exit at approximately 12:57 PM, the | K 321 | | |

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| K 321 | Continued From page 9<br>surveyor informed the Administrator of the deficiency.<br><br>NJAC 8:39-31.2 (e) | K 321 | | |
| K 341 SS=E | Life Safety Code 101<br>Fire Alarm System - Installation<br>CFR(s): NFPA 101<br><br>Fire Alarm System - Installation<br>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. Fire alarm system wiring or other transmission paths are monitored for integrity.<br>18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and review of facility provided documentation on 05/18/2023 and 05/19/2023, in the presence of the facility management, it was determined that the facility failed to provide fire alarm notification by audible and visible signals for 1 of 3 outside enclosed courtyards 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 | K 341 | 1. Facility has engaged the services of facilities fire alarm vendor to install a audio and visual alarm in the second floor smoke patio area to ensure that residents and staff who are outside on the patio are notified of emergencies. All other areas of the facility have been audited to ensure that areas requiring the audible and visual alarm have them installed and are in | 6/22/23 |

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| K 341 | Continued From page 10<br>18.5, 18.5.2.4, 24.4.2.20.9<br><br>The deficient practice was evidenced by the following:<br><br>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.<br><br>A review of the facility provided layout identified the facility as a two-story building with a basement.<br><br>Starting at approximately 9:22 AM on 05/18/2023 and continued on 05/19/2023 in the presence of the facility's AMM, a tour of the building was conducted. Along the two day tour of the facility, the surveyor inspected three (3) outside enclosed Resident courtyards with the following:<br><br>On 05/18/2023 at approximately 12:08 PM, the surveyor observed in the second (2nd) floor Residents' outside enclosed smoking area that the facility failed to have an audio and visual alarm to notify Resident, Staff, and Visitors of an activation of the building's fire alarm system.<br><br>At this time the surveyor asked the AMM, "Do you have an audio and visual alarm tied into the buildings fire alarm system." The AMM looked around and told the surveyor, no.<br><br>The AMM confirmed the findings at the time.<br><br>On 05/19/2023 during the Life Safety Code survey exit at approximately 12:57 PM, the | K 341 | working order.<br>2. All residents can be affected by this deficient practice. Dir of Maintenance and all Maintenance personnel have been in serviced on NFPA 101 related to fire alarm system installation of audio and visual alarms with specificity on requirement of installations of Audio and visual alarms.<br>3. Dir of Maintenance will audit all areas of facility weekly x 4 weeks and then monthly x 3 months or until compliance is reached to ensure that all areas of the facility/ patios requiring the installation of audio/ visual alarms will have them installed.<br>4. All the Maintenance Directors audits will be presented during the facilities monthly QAPI meeting. All concerns will be discussed and addressed immediately. | |

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| **HAMMONTON CENTER FOR REHABILITATION AND HEALTHCARE** | **43 N WHITE HORSE PIKE**<br>**HAMMONTON, NJ 08037** |

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| K 341 | Continued From page 11<br>surveyor informed the Administrator of the deficiency.<br><br>NJAC 8:39-31.2(a)<br><br>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 | K 341 | | |
| K 351 SS=E | Sprinkler System - Installation<br>CFR(s): NFPA 101<br><br>Spinkler System - Installation<br>2012 EXISTING<br>Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems.<br>In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers.<br>In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems.<br>19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1)<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and review of facility provided documentation on 05/18/2023 and 05/19/2023, in the presence of facility management it was determined that: 1) The Facility failed to properly install sprinklers, as required by CMS regulation §483.90(a) physical | K 351 | 1. All damaged or missing ceiling tiles for 2nd floor janitors closet were replaced on 5/19, ceiling tiles for the Activities Dir office, B wing server room, B wing scale room, D wing janitors closet have been replaced on 5/22 with new ceiling tiles. All | 6/22/23 |

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| K 351 | Continued From page 12<br>environment to all areas in accordance with the requirements of NFPA 101 2012 Edition, Section 19.3.5.1, 9.7, 9.7.1.1 and National Fire Protection Association (NFPA) 13 Installation of Sprinkler Systems 2012 Edition, and as required by the New Jersey Uniform Construction Code N.J.A.C. 5:23, for use group I-2 (health care) use occupancy.<br><br>The deficient practice is evidenced by the following:<br><br>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 layout which identifies the various rooms.<br><br>A review of the facility provided layout identified the facility as a two-story building with a basement.<br><br>Starting at approximately 9:22 AM on 05/18/2023 and continued on 05/19/2023 in the presence of the facility AMM, a tour of the building was conducted. Along the two (2) day tour, the surveyor observed the following locations that failed to provide proper fire sprinkler coverage:<br><br>On 05/18/2023,<br><br>1) At approximately 11:17 AM, inside the 2nd. floor janitors closet, the drop ceiling had an approximately 6 inch by 6 inch hole through the room's ceiling tile.<br><br>2) At approximately 11:34 AM, inside the 2nd. floor Activity Director's office, the drop ceiling was | K 351 | other ceiling tiles of the facility have been audited to ensure that no other ceiling tiles are damaged or missing. All ceiling tiles that were damaged or missing noted on the audit, have been replaced with new ceiling tiles.<br>2. All residents can be affected by this deficient practice. Dir of Maintenance and all Maintenance personnel have been in serviced on NFPA 101 related to Sprinkler system installations with specificity on the requirement that all areas of the facility that require ceiling tiles have them installed and are not damaged.<br>3. Dir of Maintenance will audit all areas of facility weekly x 4 weeks and then monthly x 3 months or until compliance is reached to ensure that all areas of the facility which require ceiling tiles have them installed with no damage to them.<br>4. All the Maintenance Directors audits will be presented during the facilities monthly QAPI meeting. All concerns will be discussed and addressed immediately. | |

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| K 351 | Continued From page 13<br>missing one (1) 2' by 4' and two (2) 2' by 2' ceiling tiles from the grid.<br><br>On 05/19/2023,<br><br>3) At approximately 10:34 AM, inside the B-Wing server room, there were several wires running through the ceiling tiles leaving openings in the ceiling grid.<br><br>4) At approximately 10:40 AM, inside the B-Wing scale room basement level Electrical room, the drop ceiling was missing two (2) 2' by 4' ceiling tile from the grid.<br><br>5) At approximately 11:17 AM, inside the D-Wing Janitor's closet, the drop ceiling was missing Two (2) ceiling tiles from the grid.<br><br>With the opening in the ceilings, in the event of a fire, the heat would bypass the fire sprinkler in the area and not activate the fire sprinkler system.<br><br>The AMM confirmed the findings at the time.<br><br>On 05/19/2023 during the Life Safety Code survey exit at approximately 12:57 PM, the surveyor informed the Administrator of the deficiency.<br><br>Fire Safety Hazard.<br><br>NJAC 8:39-31.1(c), 31.2(e)<br><br>NFPA 13 | K 351 | | |
| K 355<br>SS=E | Portable Fire Extinguishers<br>CFR(s): NFPA 101 | K 355 | | 6/22/23 |

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| K 355 | Continued From page 14<br>Portable Fire Extinguishers<br>Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers.<br>18.3.5.12, 19.3.5.12, NFPA 10<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and review of facility documentation on 05/18/2023 and 05/19/2023 in the presence of facility management, it was determined that the facility failed to:<br><br>1) Perform Hydrostatic testing for 16 of 28 fire extinguishers,<br>as required by National Fire Protection Association NFPA 101, 2012 Edition, Section 19.3.5.12, 9.7.4.1 and National Fire Protection Association (NFPA) 10, 2010 Edition, Sections 6.1, 6.1.3.8.1 and 6.1.3.8.3. and N.J.A.C. 5:70.<br><br>Reference #1 NFPA 10 Edition 2010 Standard for portable fire extinguishers reads,<br>- 4- 3 Inspection Maintenance.<br>- 4- 3.1 Frequency. Fire extinguishers shall be inspected when initially placed in service and thereafter at approximately 30-day intervals. Fire extinguishers shall be inspected at more frequent intervals when circumstances require.<br>- 4- 3.3 Corrective Action. When an inspection of any fire extinguisher reveals a deficiency in any conditions listed in 4- 3.2 (a), (b), (h), and (i), immediate corrective action shall be taken.<br>- 4- 3.4 At least monthly, the date the inspection was performed and the initials of the person performing the inspection shall be recorded at least monthly and that records shall be kept on a tag or label attached to the fire extinguishers.<br>- 4- 4.3 Six Year Maintenance, Every 6 years, | K 355 | 1. The Fire extinguishers located in the basement near the medical supply room, in the commercial laundry room, in the basement elevator mechanical room, near the second floor nursing station, second floor to the left of resident room C 204, second floor to the left of resident room D 213, second floor at the D Unit Nursing station, near the second floor nourishment station, second floor near the Resident salon, first floor to the left of Resident room B 115, first floor to the right of resident room C 103, first floor corridor near stairwell, first floor in the corridor near the main lobby area and the class K type fire extinguisher in the kitchen have all been hydrotested on 5/19/2023. All extinguishers in need of replacement have been replaced on 5/19/2023 and will be hydrotested at the proper time in accordance with NFPA 101 and as per the requirement to hydrotest all Fire Extinguishers in the facility. All other fire extinguishers in the facility have been hydrotested on 5/19/2023 to ensure they are in accordance with the NFPA 101 hydrotesting regulation. Any fire extinguishers needing replacement as a result of this audit have been replaced.<br>2. All residents can be affected by this deficient practice. Dir of Maintenance and | |

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| K 355 | Continued From page 15<br>stored-pressure fire extinguishers shall require a 12-year hydrostatic test shall be emptied and subjected to the applicable maintenance procedures. The removal of agent from halon agent fire extinguishers shall only be done using a listed halon recovery systems. When the applicable maintenance procedures are performed during periodic recharging or hydrostatic testing, the 6-year requirement shall be from that date.<br>- 7.3.1.1.1 Fire extinguishers shall be subjected to maintenance at intervals of not more than 1 years at the time of hydrostatic test, or when specifically indicated by an inspection or electronic notification.<br><br>The findings include the following:<br><br>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 layout which identifies the various rooms.<br><br>A review of the facility provided layout identified the facility as a two-story building with a basement.<br><br>Starting at approximately 9:22 AM on 05/18/2023 and continued on 05/19/2023 in the presence of the facility's AMM, a tour of the building was conducted.<br><br>During the two (2) day building tour the of the facility, the surveyor observed and inspected twenty eight (28) portable fire extinguishers in various locations that were last annually inspected July 2022 with the following results: | K 355 | all Maintenance personnel have been in serviced on NFPA 101 related to Hydrotesting requirement and the need to replace extinguishers that are not in compliance with the regulation.<br>3. Dir of Maintenance will audit all areas of facility monthly x 3 months or until compliance is reached to ensure that all extinguishers that are not in compliance with hydrotesting requirement are replaced with new extinguishers.<br>4. All the Maintenance Directors audits will be presented during the facilities monthly QAPI meeting. All concerns will be discussed and addressed immediately. | |

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| K 355 | Continued From page 16<br><br>On 05/18/2023,<br><br>1) At approximately 9:38 AM, the surveyor observed in the basement near the Medical supplies room, One "ABC" Type fire extinguisher near the Medical supplies room last Hydrostatic tested 2016.<br><br>2) At approximately 9:41 AM, the surveyor observed in the basement commercial laundry room, One "ABC" Type fire extinguisher last Hydrostatic tested 2015.<br><br>3) At approximately 10:16 AM, the surveyor observed in the basement Elevator mechanical room One "BC" Type fire extinguisher last Hydrostatic tested 2008.<br><br>4) At approximately 10:40 AM, the surveyor observed on the second (2nd.) floor to the right of Resident room A-203, One "ABC" Type fire extinguisher last Hydrostatic tested 2016.<br><br>5) At approximately 10:56 AM, the surveyor observed on the second (2nd.) floor at the Nursing station, One "ABC" Type fire extinguisher last Hydrostatic tested 2015.<br><br>6) At approximately 11:29 AM, the surveyor observed on the second (2nd.) floor to the left of Resident room #C-204 One "ABC" Type fire extinguisher last Hydrostatic tested 2016.<br><br>7) At approximately 11:50 AM, the surveyor observed on the second (2nd.) floor to the left of Resident room #D-213 One "ABC" Type fire extinguisher last Hydrostatic tested 2016. | K 355 | | |

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| K 355 | Continued From page 17<br>8) At approximately 10:56 AM, the surveyor observed on the second (2nd.) floor at the D- unit Nursing station, One "ABC" Type fire extinguisher last Hydrostatic tested 2014.<br><br>9) At approximately 12:01 PM, the surveyor observed on the second (2nd.) floor at the Nourishment station, One "ABC" Type fire extinguisher last Hydrostatic tested 2014.<br><br>10) At approximately 12:04 PM, the surveyor observed on the second (2nd.) floor near the Residents Salon, One "ABC" Type fire extinguisher last Hydrostatic tested 2015.<br><br>On 05/19/2023:<br>11) At approximately 10:48 AM, the surveyor observed on the first (1st.) floor to the left of Resident room B-115, One "ABC" Type fire extinguisher last Hydrostatic tested 2016.<br><br>12) At approximately 10:55 AM, the surveyor observed on the first (1st.) floor to the right of Resident room C-103, One "ABC" Type fire extinguisher last Hydrostatic tested 2016.<br><br>13) At approximately 11:09 AM, the surveyor observed on the first (1st.) floor in the corridor near the Main lobby area, One "ABC" Type fire extinguisher last Hydrostatic tested 2016.<br><br>14) At approximately 11:33 AM, the surveyor observed on the first (1st.) floor in the corridor near stairwell, One "ABC" Type fire extinguisher last Hydrostatic tested 2015.<br><br>15) At approximately 12:01 PM, the surveyor observed inside the Kitchen one Class K-Type fire extinguisher last Hydrostatic tested 2011. | K 355 | | |

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| K 355 | Continued From page 18<br>This fire extinguishers metal cylinder was damaged.<br><br>16) At approximately 12:10 PM, the surveyor observed on the first (1st.) floor Dietary corridor, One "ABC" Type fire extinguisher last Hydrostatic tested 2015.<br><br>The AMM confirmed the finding at the time of observations.<br><br>On 05/19/2023 during the Life Safety Code survey exit at approximately 12:57 PM, the surveyor informed the Administrator of the deficiency.<br><br>NFPA -10.<br><br>NJAC 8:39 -31.1 (c), 31.2 (e). | K 355 | | |
| K 364 SS=E | Corridor - Openings<br>CFR(s): NFPA 101<br><br>Corridor - Openings<br>Transfer grilles are not used in corridor walls or doors. Auxiliary spaces that do not contain flammable or combustible materials are permitted to have louvers or be undercut.<br>In other than smoke compartments containing patient sleeping rooms, miscellaneous openings are permitted in vision panels or doors, provided the openings per room do not exceed 20 square inches and are at or below half the distance from floor to ceiling. In sprinklered rooms, the openings per room do not exceed 80 square inches.<br>Vision panels in corridor walls or doors shall be fixed window assemblies in approved frames. (In fully sprinklered smoke compartments, there are no restrictions in the area and fire resistance of | K 364 | | 6/22/23 |

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| K 364 | Continued From page 19<br>glass and frames.)<br>18.3.6.5.1, 19.3.6.5.2, 8.3<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and review of facility provided documentation on 05/18/2023, in the presence of facility management, it was determined that the facility failed to prohibit transfer grills in corridor walls on resident sleeping units.<br>This deficient practice was evidenced by the following:<br><br>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 layout which identifies the various rooms.<br><br>A review of the facility provided layout identified the facility is a two-story building and a basement. The facility has 60 resident sleeping rooms on the first floor, 60 resident sleeping rooms on the second floor and various common areas on both floors.<br><br>Starting at approximately 9:22 AM on 05/18/2023 in the presence of the AMM a tour of the building was conducted.<br><br>At 12:12 PM, the surveyor observed a 19 inch by 19 inch open transfer grill installed in the corridor wall.<br><br>Further inspection identified the open transfer grill lead into an Activities storage room which housed a Heating, Ventilation and Air Conditioning (HVAC) unit inside an open closet with-in the | K 364 | 1. Facility ordered a new motorized smoke/fire damper to be installed on the second floor HVAC activities closet near the elevator. All other areas of the facility have been checked and audited to ensure no other areas need a smoke/fire damper. There were no other areas identified in need of smoke/fire damper as a result of this audit.<br>2. All residents can be affected by this deficient practice. Dir of Maintenance and all Maintenance personnel have been in serviced on NFPA 101 related to the requirement on that all Transfer grills installed in walls need to be equipped with a smoke/fire damper.<br>3. Dir of Maintenance will audit all areas of facility monthly x 3 months or until compliance is reached to ensure that all areas of the facility that have a transfer grill installed in the wall have a smoke/fire damper installed as well to prevent the spread of smoke/fire.<br>4. All the Maintenance Directors audits will be presented during the facilities monthly QAPI meeting. All concerns will be discussed and addressed immediately. | |

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| K 364 | Continued From page 20<br>storage room. The surveyor observed inside the storage room multiple combustible items.<br><br>The AMM confirmed the findings during the two day tour of the facility at the time of the inspections.<br><br>On 05/19/2023 during the Life Safety Code survey exit at approximately 12:57 PM, the surveyor informed the Administrator of the deficiency.<br><br>NJAC 8:39 - 31.2 (e). | K 364 | | |
| K 372 SS=E | Subdivision of Building Spaces - Smoke Barrie<br>CFR(s): NFPA 101<br><br>Subdivision of Building Spaces - Smoke Barrier Construction<br>2012 EXISTING<br>Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier.<br>19.3.7.3, 8.6.7.1(1)<br>Describe any mechanical smoke control system in REMARKS.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and review of facility provided documentation on 05/18/2023 and 05/19/2023 in the presence of facility management, it was determined that the facility failed to maintain the integrity of smoke barrier partitions for two (2) of ten (10) smoke barrier | K 372 | 1. On 5/22 the Maintenance Department sealed the penatration noted in the wall on 2nd floor A wing above double doors. On 5/23 the penatration in the wall on D wing above the corridor double doors was sealed with fire rated sealer in accordance | 6/22/23 |

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|---|---|---|---|
| | 315209 | A. BUILDING **01**<br>B. WING _____ | **06/05/2023** |

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| **HAMMONTON CENTER FOR REHABILITATION AND HEALTHCARE** | **43 N WHITE HORSE PIKE**<br>**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 |
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| K 372 | Continued From page 21<br>walls as evidenced by the following:<br><br>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's layout which identifies the various rooms.<br><br>A review of the facility provided layout identified the facility is a two-story building and a basement. There are five (5) smoke barrier walls on the second floor and six (6) smoke barrier walls on the first floor.<br><br>Starting at approximately 9:22 AM on 05/18/2023 and continued on 05/19/2023 in the presence of the facility's AMM, a tour of the building was conducted.<br><br>Along the two day tour, the surveyor observed the following smoke barrier walls that failed to maintain the 1/2 hour fire rated construction as required by code in the following location.<br><br>On 05/18/2023,<br><br>1) At approximately 10:35 AM, the surveyor observed above the corridor double smoke doors ceiling tiles going into the second floor "A-Wing", one approximately 1" penetration with a electrical cable running through the smoke barrier wall.<br><br>2) At approximately 11:35 AM, the surveyor observed above the corridor double smoke doors ceiling tiles going into the second floor "D-Wing", one approximately 1-1/2" penetration with a white electrical cable and one black pipe running through the smoke barrier wall. | K 372 | with NFPA 101. All other areas in the facility have been audited to ensure that there are no gaps in need of fire-resistant material. There have been no other areas in need of fire-resistant seal as a result of this audit.<br>2. All residents can be affected by this deficient practice. Dir of Maintenance and all Maintenance personnel have been in serviced on NFPA 101 related to smoke barrier construction with specificity to openings and penetrations that require NFPA approved fire rated seal.<br>3. Dir of Maintenance will audit all areas of facility weekly x 4 weeks and then monthly x 3 months or until compliance is reached to ensure that all areas of the facility that require NFPA approved fire resistance seal have been corrected.<br>4. All the Maintenance Directors audits will be presented during the facilities monthly QAPI meeting. All concerns will be discussed and addressed immediately | |

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| K 372 | Continued From page 22<br><br>These penetrations was observed on both sides through the smoke barrier wall, indicating that it was not sealed closed to prevent smoke, fumes and fire from passing through to the other smoke compartment.<br><br>The AMM confirmed the finding at the time.<br><br>On 05/19/2023 during the Life Safety Code survey exit at approximately 12:57 PM, the surveyor informed the Administrator of the deficiency.<br><br>Fire Safety Hazard.<br><br>NJAC 8:39- 31.2(e). | K 372 | | |
| K 374 SS=F | Subdivision of Building Spaces - Smoke Barrie<br>CFR(s): NFPA 101<br><br>Subdivision of Building Spaces - Smoke Barrier Doors<br>2012 EXISTING<br>Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors.<br>19.3.7.6, 19.3.7.8, 19.3.7.9<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and review of facility | K 374 | 1. On 5/24, Maintenance department | 6/22/23 |

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| K 374 | Continued From page 23<br>provided documentation on 05/18/2023 and 05/19/2023, it was determined that the facility failed to maintain smoke barrier doors to resist the transfer of smoke when completely closed for fire protection. This deficient practice was identified for 4 of 10 sets of corridor smoke barrier doors tested and was evidenced by the following:<br><br>Reference 1:<br>Life Safety Code 101, 2012 Edition,<br>- 8.5.4.1, Doors in smoke barriers shall close the opening, leaving only the minimum clearance necessary for proper operation, and shall be without louvers or grills. The clearance under the bottom of a new door shall be a maximum of 3/4 of an inch.<br><br>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 layout which identifies the various rooms.<br><br>A review of the facility provided layout identified the facility is a two-story building with ten (10) sets of double corridor smoke doors on the first and second floors.<br><br>Starting at approximately 9:22 AM on 05/18/2023 and continued on 05/19/2023 in the presence of the facility's AMM a tour of the building was conducted. Along the two (2) day tour the surveyor performed a closure test of ten (10) sets of double smoke doors in the corridors with the following results:<br><br>On 05/18/2023, | K 374 | corrected this deficient practice by adding a metal plate door sweep to the 2nd floor A wing double doors, C wing double doors, 2nd floor D wing double doors and 1st floor C wing double doors. All mentioned doors are now at 3/4 inch off the floor level. All other smoke barrier doors have been checked and audited to ensure that there are no gaps measuring more than 3/4 of an inch high off the floor level.<br>2. All residents can be affected by this deficient practice. Dir of Maintenance and all Maintenance personnel have been in serviced on NFPA 101 related to smoke barrier doors and the requirement to ensure that there are no gaps measuring more than 3/4 of an inch high off the floor level in accordance with NFPA 101.<br>3. Dir of Maintenance will audit all smoke barrier doors of facility weekly x 4 weeks and then monthly x 3 months or until compliance is reached to ensure that all smoke barrier doors have no gaps measuring more than 3/4 of an inch from the floor to the bottom of the door.<br>4. All the Maintenance Directors audits will be presented during the facilities monthly QAPI meeting. All concerns will be discussed and addressed immediately. | |

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| K 374 | Continued From page 24<br><br>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.<br><br>This test was repeated two additional times with the same results.<br><br>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.<br><br>This test was repeated two additional times with the same results.<br><br>3) At approximately 11:44 AM, during a closure test of the 2nd. floor "D- Wing" double smoke doors in the corridor next to Resident room #D-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 1/4 inch wide by 7 inch high gap along the bottom meeting edge of the doors.<br><br>This test was repeated two additional times with the same results.<br><br>This would allow the transfer of smoke, fire, and poisonous gasses to pass from one smoke | K 374 | | |

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| K 374 | Continued From page 25<br>compartment to another in the event of a fire.<br><br>On 05/19/2023,<br><br>4) At approximately 10:59 AM, during a closure test of the 1st. floor "C- Wing" double smoke doors in the corridor near Resident room #C-103 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.<br><br>This test was repeated two additional times with the same results.<br><br>This would allow the transfer of smoke, fire, and poisonous gasses to pass from one smoke compartment to another in the event of a fire.<br><br>The AMM confirmed the findings during the two day tour of the facility at the time of the inspections.<br><br>On 05/19/2023 during the Life Safety Code survey exit at approximately 12:57 PM, the surveyor informed the Administrator of the deficiency.<br><br>N.B. 8:39-31.1(c), 31.2(e) | K 374 | | |
| K 521<br>SS=E | HVAC<br>CFR(s): NFPA 101<br><br>HVAC<br>Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. | K 521 | | 6/22/23 |

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| K 521 | Continued From page 26<br>18.5.2.1, 19.5.2.1, 9.2<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observations on 05/18/2023 and 05/19/2023 in the presence of facility management, it was determined that the facility failed to ensure that the facility's ventilation systems were being properly maintained for 5 of 14 Resident bathroom exhaust systems as per the National Fire Protection Association (NFPA) 90A.<br><br>This deficient practice was evidenced by the following:<br><br>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 layout which identifies the various rooms and smoke compartments in the facility.<br><br>A review of the facility provided layout identified the facility as a two-story building with 120 Resident sleeping rooms and various common areas.<br><br>Starting at approximately 9:22 AM on 05/18/2023 and continued on 05/19/2023 in the presence of the facility's AMM a tour of the facility was conducted. Along the two (2) day tour the surveyor inspected and tested ten (10) Resident sleeping room bathrooms and four (4) shower room bathroom exhaust systems. | K 521 | 1. Exhaust fans in rooms B110 and B111-bathroom, resident bathroom B113 were corrected on 5/22/23. Exhaust vents in resident bathroom D108 and resident bathroom in D 112 have all been corrected on 5/23/23 and are now in good working condition. All other exhaust fans in resident rooms and bathrooms have been checked and audited to ensure that they are in good working order. No other concerns were noted with any other exhaust fans as a result of this audit<br>2. All residents can be affected by this deficient practice. Dir of Maintenance and all Maintenance personnel have been in serviced on NFPA 101 related to HVAC ventilation and the requirement for all exhaust fans to be in good working condition.<br>3. Dir of Maintenance will audit all exhaust fans of facility weekly x 4 weeks and then monthly x 3 months or until compliance is reached to ensure that all exhaust fans are in good working condition and are providing the various areas of the facility with proper ventilation.<br>4. All the Maintenance Directors audits will be presented during the facilities monthly QAPI meeting. All concerns will be discussed and addressed immediately. | |

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| K 521 | Continued From page 27<br><br>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:<br><br>On 05/19/2023,<br><br>1. At approximately 10:40 AM, inside Resident room #B-110 bathroom, when tested the exhaust system did not function properly.<br><br>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.<br><br>This bathroom would rely on mechanical ventilation.<br><br>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.<br><br>This bathroom would rely on mechanical ventilation.<br><br>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.<br><br>This bathroom would rely on mechanical ventilation.<br><br>4. At approximately 11:21 AM, inside Resident | K 521 | | |

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| K 521 | Continued From page 28<br>room #D-108 bathroom, when tested the exhaust system did not function properly. This bathroom had no window with an area that would open.<br><br>This bathroom would rely on mechanical ventilation.<br><br>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.<br><br>This bathroom would rely on mechanical ventilation.<br><br>The AMM confirmed the findings at the time of observations.<br><br>On 05/19/2023 during the Life Safety Code survey exit at approximately 12:57 PM, the surveyor informed the Administrator of the deficiency.<br><br>NFPA 90A.<br><br>NJAC 8:39- 31.2 (e). | K 521 | | |
| K 918 SS=E | Electrical Systems - Essential Electric Syste<br>CFR(s): NFPA 101<br><br>Electrical Systems - Essential Electric System Maintenance and Testing<br>The generator 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. Maintenance and testing of the generator and | K 918 | | 6/22/23 |

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| K 918 | Continued From page 29<br>transfer switches are performed in accordance with NFPA 110.<br>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.<br>6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview on 05/18/2023 and 05/19/2023 in the presence of the facility management, it was determined that the facility failed to ensure a remote manual stop station for 1 of 1 emergency generators was installed in accordance with the requirements of NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1.<br><br>The deficient practice was evidenced by the following: | K 918 | 1. The facility contacted its generator service vendor for them to install a remote emergency stop button. Generator vendor and facility will schedule a date for service to install the required Emergency stop button. Facility has only one generator.<br>2. All residents can be affected by this deficient practice. Dir of Maintenance and all Maintenance personnel have been in serviced on NFPA 101 related to the requirement of facility generators to have an Emergency stop Button installed and in | |

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| K 918 | Continued From page 30<br>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.<br><br>The AMM told the surveyor, yes we have one Diesel Emergency Generator.<br><br>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 where the Emergency Generator is located, the surveyor observed that the emergency stop button was located on the front control panel of the generator.<br><br>At this time the surveyor asked the AMM, "Do you have a remote emergency stop button for the generator." The AMM said, no.<br><br>The AMM confirmed the finding at the time of observation.<br><br>On 05/19/2023 during the survey exit at approximately 12:57 PM, the surveyor informed the Administrator of the deficiency.<br><br>NJAC 8:39-31.2(e), 31.2(g)<br><br>NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. | K 918 | good working condition.<br>3. Dir of Maintenance will audit the generator weekly x 4 weeks and then monthly x 3 months or until compliance is reached to ensure that the Emergency stop button is in good working condition.<br>4. All the Maintenance Directors audits will be presented during the facilities monthly QAPI meeting. All concerns will be discussed and addressed immediately. | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

# POST-CERTIFICATION REVISIT REPORT

| PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER | MULTIPLE CONSTRUCTION | DATE OF REVISIT |
|---|---|---|
| 315209 Y1 | A. Building 01 - MAIN BUILDING 01<br>B. Wing Y2 | 8/1/2023 Y3 |

| NAME OF FACILITY | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HAMMONTON CENTER FOR REHABILITATION AND HEALTHCARE | 43 N WHITE HORSE PIKE<br>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).

| ITEM Y4 | | DATE Y5 | ITEM Y4 | | DATE Y5 | ITEM Y4 | | DATE Y5 |
|---|---|---|---|---|---|---|---|---|
| ID Prefix | | Correction | ID Prefix | | Correction | ID Prefix | | Correction |
| Reg. # | NFPA 101 | Completed | Reg. # | NFPA 101 | 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 101 | 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 101 | 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 101 | 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 | | |

| REVIEWED BY STATE AGENCY ☐ | REVIEWED BY (INITIALS) | DATE | SIGNATURE OF SURVEYOR | DATE |
|---|---|---|---|---|
| REVIEWED BY CMS RO ☐ | REVIEWED BY (INITIALS) | DATE | TITLE | DATE |

| FOLLOWUP TO SURVEY COMPLETED ON | |
|---|---|
| 6/5/2023 | ☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO |