STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315310	A. BUILDING _____ B. WING _____	C 08/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALARIS HEALTH AT HARBOR VIEW	178-198 OGDEN AVE JERSEY CITY, NJ 07307

(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
F 000	INITIAL COMMENTS COMPLAINT#: NJ126888 CENSUS: 152 SAMPLE SIZE: 4 F689 IJ Based on observations, interviews, medical record (MR) review, and review of other pertinent facility documentation on 8/8/2019, it was determined that the facility failed to protect and ensure that a [redacted] cognitively impaired resident who had a known history of [redacted] prior to admission to the facility and also a history of [redacted] in the facility, was safe from [redacted] and was appropriately monitored and / or supervised by the facility staff to prevent elopement for 1 of 4 sampled residents (Resident #2), reviewed for [redacted] On [redacted] Resident #2 was able to leave the unit and exit the building unescorted through the front entrance/exit door which did not alarm. On [redacted] at approximately 1:50 p.m., Receptionist #2 received a telephone call from a neighbor/individual in the community who wanted to clarify that Resident #2 was a resident of the facility. The Receptionist checked the log at the front desk which included a list of names of residents in the facility and saw Resident #2's name in the log. The individual who called told the Receptionist that Resident #2 told the caller that Resident #2 lost his/her pocket book and the individual arranged transportation for the Resident. The Receptionist notified Resident #2's	F 000		

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

Electronically Signed | 09/06/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 000	Continued From page 1 nurse/ the Assistant Director of Nursing (ADON), and a search was initiated in the building but the staff were unable to find Resident #2. The individual who notified the facility of Resident #2 being missing was able to track the transportation and returned the Resident to the facility. Resident #2 was missing from the facility on 8/4/2019, from approximately 1:11 p.m. to 2:35 p.m., when the Resident was returned to the facility. The facility also failed to ensure that the [redacted] was functioning appropriately to prevent residents with a history of wandering and with a [redacted] from elopement for 2 of 4 sampled residents (Resident #2 and Resident #3), reviewed for [redacted] functioning to prevent [redacted], as well as failed to follow the facility's own policies titled "Wanderers- Search/Missing Persons, [redacted] and Daily Door Alarm Inspection Policy." This placed Resident #2 and Resident #3, as well as all other residents at risk for [redacted] in an Immediate Jeopardy (IJ) situation. This situation was identified as an IJ situation on 8/8/2019 at 4:30 p.m., and was reported to the Administrator, Director of Nursing (DON) and Regional Administrator of the facility. The IJ ran from 8/4/2019 at 1:11 p.m., when Resident #2 exited the building unattended through 8/8/2019 at 4:00 p.m., when the new alarm system was put into place and was lifted that same day at 4:30 p.m., when the facility implemented an acceptable Removal Plan.	F 000		
F 689 SS=K	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that -	F 689		8/8/19

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F 689	Continued From page 2 §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: C#: NJ126888 Based on observations, interviews, medical record (MR) review, and review of other pertinent facility documentation on 8/8/2019, it was determined that the facility failed to protect and ensure that a [redacted] cognitively impaired resident who had a known history of [redacted] prior to admission to the facility and also a history of [redacted] in the facility, was safe from [redacted] and was appropriately monitored and / or supervised by the facility staff to prevent [redacted] for 1 of 4 sampled residents (Resident #2), reviewed for [redacted]. On [redacted] Resident #2 was able to leave the unit and exit the building unescorted through the front entrance/exit door which did not alarm. On [redacted] at approximately 1:50 p.m., Receptionist #2 received a telephone call from a neighbor/individual in the community who wanted to clarify that Resident #2 was a resident of the facility. The Receptionist checked the log at the front desk which included a list of names of residents in the facility and saw Resident #2's name in the log. The individual who called told the Receptionist that Resident #2 told the caller that Resident #2 lost his/her pocket book and the individual arranged transportation for the Resident. The Receptionist notified Resident #2's nurse/ the Assistant Director of Nursing (ADON), and a search was initiated in the building but the	F 689	The facility has identified factual inaccuracies in the SOD, however, we are responding with the POC as CMS requires. Immediately upon Resident #2□s return, body assessment and vital signs were taken. [redacted] returned to the facility with no injury or signs of pain. Q15minute monitoring was initiated. The physician ordered to send Resident #2 to ER for further evaluation. Resident #2□s [redacted] was tested and observed to be functioning properly. Resident #2 returned from the hospital on [redacted] at 12am with no injury or harm. New [redacted] assessment was completed as well. Immediately upon Resident #2□s return to the facility, the [redacted] was tested at both entrances to the facility. It was determined at the time of [redacted] there was intermittent failure of the [redacted]. It was initiated that a staff member would be seated in the lobby 24 hours per day with view of both doors to secure the facility and all residents with [redacted] were put on q15 minute monitoring. Service call was placed to Plant Operations Director to further inspect the	

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F 689	Continued From page 3 staff were unable to find Resident #2. The individual who notified the facility of Resident #2 being missing was able to track the transportation and returned the Resident to the facility. Resident #2 was missing from the facility on 8/4/2019, from approximately 1:11 p.m. to 2:35 p.m., when the Resident was returned to the facility. The facility also failed to ensure that the [redacted] was functioning appropriately to prevent residents with a history of [redacted] and with a [redacted] from [redacted] for 2 of 4 sampled residents (Resident #2 and Resident #3), reviewed for [redacted] functioning to prevent [redacted], as well as failed to follow the facility's own policies titled [redacted] Search/Missing Persons, [redacted] and Daily Door Alarm Inspection Policy." This placed Resident #2 and Resident #3, as well as all other residents at risk for [redacted] in an Immediate Jeopardy (IJ) situation. This situation was identified as an IJ situation on 8/8/2019 at 4:30 p.m., and was reported to the Administrator, Director of Nursing (DON) and Regional Administrator of the facility. The IJ ran from 8/4/2019 at 1:11 p.m., when Resident #2 exited the building unattended through 8/8/2019 at 4:00 p.m., when the new alarm system was put into place and was lifted that same day at 4:30 p.m., when the facility implemented an acceptable Removal Plan. This deficient practice was evidenced by the following: 1. According to the "Admission Record (AR)" Resident #2 was admitted to the facility on [redacted] with diagnoses which included but were not limited to [redacted]	F 689	[redacted] Resident #3 was also placed on q15 minute monitoring. New wander guard system was installed on 8/8/19 as of 4pm and in-service was initiated to inform staff about new [redacted] r [redacted]. All residents with [redacted] were given new [redacted] that correspond with the new alarm system. [redacted] were activated and tested for function when put on the resident. All residents with [redacted] will have the potential to be affected by the cited deficient practice. All residents with [redacted] were put on q15 minute monitoring and a staff member was assigned to be seated in the lobby 24 hours per day with view of both doors as [redacted] while waiting for new alarm system to be delivered and installed. Q15 minute monitoring and staff member seated in the lobby 24 hours per day with view of both doors, put in place. Administrator in-serviced all staff on elopement policy and procedure. All residents with [redacted] whether high or low risk for elopement will have a picture at reception desk. New [redacted] was installed on 8/8/19 at both entrances. During transition to new alarm system, the safeguards of q15minute monitoring and 24 hour staff member seated in the lobby remained in place. On [redacted] was also installed at the elevator on the [redacted].	

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F 689	Continued From page 4 and Restlessness and Agitation. According to the Minimum Data Set (MDS), an assessment tool dated [redacted], Resident #2 had a Brief Interview for Mental Status (BIMS) score of [redacted] which indicated the Resident was [redacted] cognitively impaired. The MDS also indicated that Resident #2 required limited assistance with ambulation and activities of daily living (ADLs). Review of Resident #2's Care Plan (CP) initiated [redacted], showed under: "Focus": The Resident was "an [redacted]." Under "Goal"; dated [redacted], included the Resident's "safety will be maintained...." Under "Interventions"; dated [redacted], included "distract resident from [redacted] by offering pleasant diversions, structured activities, food, conversation, television (and) book." Further review of Resident #2's CP initiated [redacted] under: "Focus": revealed the Resident was "disoriented to place." Under": Interventions"; included "identify pattern of [redacted] Is [redacted] purposeful, aimless, or escapist (looking for distraction)? Is resident looking for something?.... Monitor location every frequently...." Review of Resident #2's [redacted] an assessment tool used to determine the severity of residents risk for elopement, with "a score of [redacted] higher is at risk for [redacted]," revealed the following: On [redacted] the resident scored a [redacted] after the resident [redacted] which indicated the resident was at high risk for [redacted], the assessment	F 689	Elopement assessments will continue to be completed on all new admissions, quarterly thereafter, and if any changes observed in resident□s exit seeking behaviors. RN Supervisor continuing to test the door alarms q shift as was in place previously. RN Supervisor continuing to test [redacted] for proper functioning q shift as was in place previously. RN Supervisor will now test [redacted] elevator alarm q shift as well. Maintenance Director and/or designee tests the door and elevator alarms for proper function 2 times per day. [redacted] will be tested once per week by Administrator. Any identified issues of door alarm system will be reported to the Administrator immediately. [redacted] audit forms will be reviewed twice per month by Administrator. Nursing management team will review all residents with [redacted] monthly for appropriate use of wander guard bracelets. Recreation Director will audit wander guard pictures twice per month to assure all pictures are in place. Administrator maintains master list of all residents with [redacted] Results of all audit tools including door testing, [redacted] function, resident photo audit, and master list of residents with [redacted] will be reviewed by the Administrator and discussed on a monthly basis with the Quality Assurance Committee for a period of 6 months, at	

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F 689	Continued From page 5 showed the resident was disoriented at all times, had poor safety awareness, was a new admission and had a history of 1-2 episodes of elopement attempts for the last 6 months. On [redacted] resident scored an [redacted] indicated the resident was at high risk for elopement, the assessment showed the resident was disoriented at all times, was a new admission and had a history of 1-2 episodes of [redacted]t attempts for the last 6 months. On [redacted] and [redacted] the resident scored a [redacted], which indicated the resident was at low risk for [redacted]t, the assessment showed the resident was responsive to redirection, was more than 120 days without [redacted] and had a history of 1-2 episodes of [redacted] attempts for the last 6 months. On [redacted] and [redacted], the resident scored a [redacted] which indicated the resident was at low risk for [redacted], the assessment showed the resident was responsive to redirection, was more than 120 days without [redacted], and no history of [redacted] attempts for the last 6 months. Review of Resident #2's Progress Notes (PN) dated [redacted] at 6:20 p.m., revealed Resident #2 was "alert with periods of confusion but able to make need (s) known to staff...." The PN also revealed "the resident walks [redacted] and was at risk for [redacted]" Review of Resident #2's "IDT (Interdisciplinary Team) Meeting Note- Care Plan Review" dated [redacted] at 11:50 a.m., showed the Resident was "at risk for wandering, [redacted] in place...." Review of the Facility Reportable Event (FRE)	F 689	which time Quality Assurance Committee will review the necessity and frequency of further audits. The results of these audits will also be discussed by Administrator on a monthly basis during Safety Meeting with the interdisciplinary team.	

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dated [redacted], revealed at approximately 1:50 p.m., the Receptionist informed the [redacted] nurse that Resident #2 had exited the building and he/she was made aware by a neighbor. The FRE also showed that the Receptionist reported that the "neighbor called the facility reporting (Resident #2) had walked down the street looking for (his/her) house." The FRE also revealed that "at 2:00 p.m., it was noted the resident was not in the facility. Staff searched the perimeter of the facility at this time."

Further review of the FRE revealed that by 2:15 p.m., Resident #2's whereabouts was confirmed after speaking with the neighbor who assisted the resident by calling transportation and was tracking (Resident #2's) location via the transportation application. In addition, the FRE included that the neighbor reported Resident #2 "stated (he/she) was a [redacted] and needed to get back home after working at (the facility)." The FRE also revealed that Resident #2 "exited the building via the front door and the alarm did not sound when (the Resident) exited the building.... However, when (Resident #2) was brought back to the building the alarm did sound and (his/her) [redacted] device was found to be in good working order...."

Review of the Incident Report (IR) dated [redacted] revealed that at 2:00 p.m., staff reported Resident #2 was missing on the [redacted]. The IR further indicated that the [redacted] protocol was initiated and a search was done on all units and areas surrounding the building.

Review of Resident #2's PN dated [redacted] at 3:52 p.m., showed Resident #2 was noted

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F 689	Continued From page 7 missing at approximately 2:00 p.m., brought back to the facility at 3:00 p.m., the physician was notified and ordered to send Resident #2 to the hospital for post [redacted] evaluation. After the incident Resident #2's PN dated [redacted] at 10:55 p.m., revealed that Resident #2 was an "active exit seeker wanting to go home to see his/her mother." The PN also showed 15 minutes monitoring was initiated and in progress. In addition, the PN showed Resident #2 was "very restless and pacing the floor to exhaustion and refused to rest." Further review of the PN revealed Resident #2 was transferred to the hospital for evaluation. Review of Resident #2's PN dated [redacted] at 2:07 a.m., revealed that Resident #2 returned to the facility from the hospital at 12:00 a.m. Resident #2's PN also showed that the facility's physician was notified of the Resident's return and [redacted] monitoring was in progress. Review of Resident #2's "Order Summary Report (OSR)," updated after the Resident's hospital visit revealed the following: [redacted] placement every shift, dated [redacted]. Check [redacted] tion every shift to right arm, dated [redacted] Review of the [redacted] Audit" log showed that the function of the front and rear exit doors was checked as follows: For the month of June 2019, at 7:00 a.m., 3:00 p.m., and 11:00 p.m.	F 689		

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For the month of July 2019, at 7:00 a.m., 3:00 p.m., and 11:00 p.m.
For the month of August 2019, at 7:00 a.m., 3:00 p.m., and 11:00 p.m., from the first to the seventh.

During an interview with Resident #2 on 8/8/2019 at 10:30 a.m., the Resident stated that he/she had never left the facility without telling anyone he/she does not know the area.

During an interview with the Certified Nursing Assistant (CNA #1) on 8/8/2019 at 12:35 p.m., the CNA stated on [redacted] at approximately 1:10 p.m., he/she observed Resident #2 in the wheelchair, down the hallway going towards the Resident's room. The CNA also stated "the Resident is always moving around the unit." In addition, CNA #1 explained that he/she was on break when Resident #2 went missing and was called by the ADON to find out if the CNA saw Resident #2. CNA #1 also indicated the CNA told the ADON that he/she last saw Resident #2 in the day room. CNA #1 also stated that the CNA was told by the ADON he/she "has to come and help look for (Resident #2) because (the Resident) was missing."

During an interview with the ADON on 8/8/2019 at 1:05 p.m., the ADON stated he/she took a break at 1:10 p.m., and returned to the unit at 1:35 p.m. The ADON also stated around 1:50 p.m., the Receptionist (Receptionist #2) called the ADON and asked if he/she can see "if (Resident #2) is there, somebody called and said (Resident #2) was outside." The ADON also indicated he/she immediately notified the Nursing Supervisor and a search was initiated inside of the building, when Resident #2 could not be found the ADON

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checked outside of the building to see if Resident #2 "was on the street, (but) he/she could not find (the Resident...." The ADON explained that he/she spoke with the neighbor and the neighbor told the ADON that he/she saw Resident #2 walking and asked the Resident "if he/she was okay?" The ADON further explained that the neighbor told the ADON that Resident #2 said he/she was a [redacted] at the facility and lost his/her pocket book, so the Resident did not have money to pay for the ride, feeling sorry for Resident #2, the neighbor called transportation for the Resident. The ADON also indicated that the neighbor also informed the ADON that he/she was tracking the transportation and was on his/her way to pick up the Resident. The ADON stated he/she started driving towards the direction reported by the neighbor to look for Resident #2, however, the ADON was unable to find Resident #2. In addition, the ADON stated when he/she returned to the facility, Resident #2 had already returned to the facility by the neighbor who initially called to inquire about Resident #2.

During an interview on 8/8/2019 at 3:55 p.m., with Receptionist #1, the Receptionist stated "if a Resident is at risk for [redacted], they will have to go through me...." In addition, Receptionist #1 stated there was a folder at the front desk with current Residents' in the facility names, and that was how she would identify residents in the facility who were [redacted] risk. However, the Receptionist was unaware of the pictures at the front desk to identify residents who were at risk for [redacted].

During a phone interview on 8/8/2019 at 4:10 p.m., with Receptionist #2, who was on duty at the time of the [redacted], the Receptionist stated

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on [redacted] someone from outside called the facility's front desk to inquire if Resident #2 was a Resident of the facility. The Receptionist indicated that he/she did not know if Resident #2 was a Resident of the facility and checked the list of residents names at the front desk for Resident #2's name, which was given to the Receptionist by the caller. Receptionist #2 stated he/she then notified the ADON of the call he/she received. In addition, Receptionist #2 explained that he/she never met Resident #2 and did not know what the Resident looked like and was only familiar with the residents who usually came down to the dining room. Receptionist #2 also stated that pictures of residents who were [redacted] risks were not at the front desk on Sunday, when Resident #2 [redacted]. Receptionist #2 also explained pictures of residents at risk for [redacted] used to be at the front desk but the pictures were not there because of a previous leak which damaged some items and the items were removed. In addition, Receptionist #2 indicated he/she did not know the other Residents who were [redacted] risks.

During a tour with the Maintenance Director on 8/8/2019 at 11:25 a.m., the Maintenance Director stated he/she does an audit of the [redacted] 3 times a day and check the exit doors every shift.

During an interview with the Maintenance Director on 8/8/2019 at 11:29 a.m., the Maintenance Director stated Resident #2 "tried the side door first, but it is a better door so (the Resident) went through the main exit door.

2. According to the AR, Resident #3 was admitted to the facility on [redacted] with

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALARIS HEALTH AT HARBOR VIEW	178-198 OGDEN AVE JERSEY CITY, NJ 07307

(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
F 689	Continued From page 11 diagnoses which included but were not limited to; [redacted] According to the "Admit/Readmit Screener," an assessment tool dated [redacted] Resident #3 was [redacted] and oriented to [redacted], and [redacted] and was verbally appropriate. In addition, the "Admit/Readmit Screener-", also indicated that Resident #3 needed assistance with ADLs. Review of Resident #3's PN dated [redacted] at 1:22 p.m., showed on [redacted], during the 7 a.m. to 3 p.m. shift, Resident #3 was "noted with repeated behavior of going up and down the facility via elevator." Resident #3's PN also showed that the Resident stated he/she did not belong in the facility and wanted to go home. In addition, the PN also revealed that the Unit Manager (UM), ADON, DON (Director of Nursing) and Social Worker (SW) were notified and a [redacted] was applied to Resident #3's [redacted]t and the "Resident's whereabouts monitored at all times." Review of Resident #3's ER assessment dated [redacted] at 7:05 a.m., showed Resident #3 scored a 16, which indicated Resident #3 was at high risk for [redacted] Review of Resident #3's "OSR" revealed the following: [redacted] on [redacted] every shift, every 90 days replace [redacted] device, dated [redacted] [redacted] on [redacted] every night shift checks for function, dated [redacted]	F 689		

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F 689	Continued From page 12 [redacted] on [redacted] every shift checks for placement, dated [redacted]. Review of Resident #3's CP initiated [redacted] showed under Focus the Resident was "an [redacted]/wanderer." Under: Goal included the Resident's safety will be maintained through the review date, dated [redacted] Under: Interventions included "Approach resident in a calm manner and attempt to redirect when wandering in an inappropriate area...." and "monitor resident for episode of wandering, place residents' picture at nurses' station and front desk...." During the course of the survey, a test was conducted of Resident #2 and Resident #3 [redacted] with the [redacted] the following was observed: On [redacted] at 12:00 p.m., Resident #2 was wheeled to the rear exit/entrance doors leading into the parking lot by the activity staff on two attempts, the doors failed to lock and the [redacted] did not activate and/or alarm, allowing Resident #2 to exit the facility. The Administrator was then called and two additional attempts and/or tests were conducted on Resident #2's [redacted] and the [redacted] did not activate, allowing the resident to exit the rear entrance/exit doors on both attempts. The Maintenance Director then adjusted the [redacted], which then activated the [redacted] and caused the doors to lock and [redacted] to alarm. During an interview with the Administrator at the time of testing Resident #2's [redacted]	F 689		

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F 689	Continued From page 13	F 689		

[redacted] with the [redacted] system on [redacted] at 12:10 p.m., the Administrator stated "this is why we are trying to change the system to a Bluetooth system, it is better." In addition, the Administrator stated, "the system is being updated because the system didn't work when the Resident (Resident #2) exited, which is crazy." The Administrator also explained that the [redacted] uses radio frequency, so when there is a cell phone close by this caused the doors to malfunction. The Administrator also indicated that the facility staff realized the system needed an upgrade after the incident and wrote this in the summary and conclusion to the New Jersey Department of Health (NJDOH).

On [redacted] at 12:22 p.m., Resident #3 walked towards the facility's rear entrance/exit doors leading into the parking lot, escorted by the [redacted]. The [redacted] failed to activate and the door failed to lock and/or alarm, allowing the Resident to exit the facility's rear entrance/exit doors leading into the parking lot. However, upon Resident #3 walking back into the facility through the rear entrance/exit doors, the [redacted] activated and the alarm sounded.

During an interview with the Administrator at the time of testing Resident #3's [redacted] with the [redacted] on [redacted] 9 at 12:25 p.m., the Administrator stated "this is a conundrum (a confusing and difficult problem or question)." The Administrator also stated that is why we are changing the system and everyone with [redacted] is on monitoring every 15 minutes.

Review of the facility's policy titled [redacted]

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F 689	Continued From page 14	F 689		

Search/Missing Persons" updated 1/16/2019, included but was not limited to the following: Under "Policy": it is the policy of the facility to monitor the whereabouts of all residents.

Review of the facility's policy titled [redacted] updated 1/19/2019, included but was not limited to the following: Under "Policy": It is the policy of the facility to utilize [redacted] system for selected residents with a known behavior of wandering beyond their unit of residence as an adjunct to safety measures typically in place such as door alarms on stairways. Under "Procedure #4" Activating the system: When a resident wearing the [redacted] approaches the front or rear glass doors of the lobby, the [redacted] will sound. At the desk in the lobby there will be an audible sound. The receptionist or any other nearby personnel should then redirect the resident. The nurse of the resident's floor should be notified and should document the attempted [redacted] making all care givers on the floor aware so that they can increase their awareness of resident's location. The nurse will make an announcement over the PA System "Code Gray...."

Review of the facility's policy titled "Daily Door Alarm Inspection Policy" dated 1/19/2019, included but was not limited to the following: Under "Goal" To ensure that all doors/door alarms are inspected on a daily basis. Under "Procedure":
1. Inspections shall be done on a daily basis by maintenance staff to ensure that door alarms activate when doors are opened. When strobes or read out panels are in place the inspection shall include checking strobes and that panel is receiving a signal and is lighting up.

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F 689	Continued From page 15 2. In the event of a door alarm, strobe or panel being found to be defective, it is to be reported immediately to the administrator or department supervisor, if the system cannot be repaired by in house maintenance, the regional maintenance director should then be notified. N.J.A.C:8:39-33.1(d)	F 689		