STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315244	A. BUILDING **01** B. WING _____	**07/26/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED CARE AT ABSECON	**1020 PITNEY ROAD** **ABSECON, NJ 08201**

(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
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 07/25 and 26/ 2022 and Preferred Care at Absecon was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. Preferred Care at Absecon two story, Type II Protected building that was built in May 2010. The facility is divided into 10 smoke zones.	K 000		
K 311 SS=E	Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 EXISTING 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 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. This REQUIREMENT is not met as evidenced by: Based on observations on 07/25/2022, in the presence of facility Management, it was determined that the facility failed to ensure that 2 of 16 exit stairwell doors were capable of maintaining the two hour fire rated construction. This deficient practice was evidenced by the	K 311	1a. The door keeper was installed for the stairwell door next to room [redacted] and the door successfully latched into the frame. 1b. The paint was removed from the latching mechanism for the door next to	8/26/22

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

Electronically Signed | 08/18/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315244	A. BUILDING **01** B. WING _____	**07/26/2022**

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K 311	Continued From page 1 following, On 07/25/2022 starting at 9:05 AM, during the building tour with the Facility's Director of Maintenance (DOM), when the surveyor performed a closure test of the sixteen (16) 1-1/2 hour fire rated doors leading into the stairwells, two (2) fire rated doors did not positive latch into their frames as required by code to maintain the fire rated construction in the following locations, 1. At 10:13 a.m., on the [redacted] floor. one 1-1/2 hour fire rated stairwell door next to room [redacted] when tested and allowed to self-close 3 times, the door did not positive latch into its frame. The surveyor observed this 1-1/2 hour fire rated door had no means to positive latch into its frame. The surveyor observed that the door frame had the keeper removed. 2. At 10:21 a.m., on the [redacted] floor one 1-1/2 hour fire rated stairwell door next to the classroom when tested and allowed to self-close 3 times, the door did not positive latch into its frame. At that time the DOM said to the surveyor, that the doors latching mechanism was painted in the open position. When the fire alarm is activated, the magnetic door hold closed devices would de-energize and unlock. These stairwell doors would need to positive latch into its frame to maintain the fire rated construction to prevent fire, smoke and poisonous gases to enter the exit stairwell in the event of a fire.	K 311	the classroom and successfully latched into the frame 2. The deficiency cited under K311, if not corrected, would potentially present a fire and safety hazard to all residents, staff, and the public. 3. All maintenance staff were in-serviced on life safety and the importance of having secured doors in the event of a fire. 4. The maintenance director or designee will monitor, by making rounds on a daily basis, that these deficiencies do not reoccur. They are also ensuring that the staff is adhering to all in services. All findings will be given to the quarterly quality assurance committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315244	A. BUILDING **01** B. WING _____	**07/26/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED CARE AT ABSECON	**1020 PITNEY ROAD** **ABSECON, NJ 08201**

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K 311	Continued From page 2 NJAC 8:31.2 (e).	K 311		
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour 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. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and review of facility documentation on 07/25/2022 and 7/26/2022, in the presence of facility management, it was	K 321	1. A door closer was installed onto the medical records room door allowing it to self-close into its frame.	8/26/22

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PREFERRED CARE AT ABSECON	**1020 PITNEY ROAD** **ABSECON, NJ 08201**

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K 321	Continued From page 3 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. This deficient practiced was evidenced by the following: During the survey entrance on 07/25/2022 at 8:42 AM, a request was made to the facility's Director of Maintenance (DOM) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. On 07/26/2022 (day two of survey) the surveyor conducted a tour of the [redacted] building in the presence of the DOM. At 10:26 AM an inspection of the Medical Records room was performed. The surveyor observed that the 3/4 hour fire rated corridor door leading into the Medical Records room was in the open position and had no means to self-close the door into its frame. The surveyor observed inside the room, 10 four drawer filing cabinets filled with combustible medical records. There were approximately 20 combustible records stored on top of the filing cabinets and desks. Inside an adjacent room with-in the room were 20 banker size boxes on a pallet and 18 boxes on the floor filled with combustible medical records. The door failed to self-close into its frame as	K 321	2. The deficiencies cited under K321, if not corrected, would potentially present a fire and safety hazard to all residents, staff, and the public. 3. All maintenance staff were in-serviced on life safety and the importance of fire rated doors self-closing. 4. The maintenance director or designee will monitor, by making rounds on a daily basis, that this deficiency does not reoccur. They are also ensuring that the staff is adhering to all in services. All findings will be given to the quarterly quality assurance committee.	

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	315244	A. BUILDING **01** B. WING _____	**07/26/2022**

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K 321	Continued From page 4 required by code. A review of an evacuation diagram posted in the area identified that the Medical Records room was in the primary exit access path to reach an exit. This condition would allow fire, smoke and poisonous gases to pass from the Medical Records room into the exit access corridor in the event of a fire. The findings were verified and confirmed by the DOM during the observations. The surveyor informed the Administrator of the findings at the Life Safety Code exit conference on 07/26/2022 at approximately 1:30 PM. NJAC 8:39-31.2 (e) Life Safety Code 101	K 321		
K 355 SS=F	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and review of facility documentation on 7/25/2022 and 7/26/2022, in the presence of facility management, it was determined that the facility failed to install portable fire extinguishers with-in the required height for 12 of 43 fire extinguishers, in	K 355	1. Fire extinguishers numbers 7, 29, fire extinguisher located next to the medical records room, fire extinguisher located next to exit door #7, fire extinguisher located next to the clean linen room, fire extinguisher located near resident room	8/26/22

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K 355	Continued From page 5 accordance with the requirements of 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. The evidence includes the following: Reference #1 NFPA 10 - 6.1.3.8 Installation Height. - 6.1.3.8.1 Fire extinguishers having a gross weight not exceeding 40 lb shall be installed so that the top of type fire extinguisher is not more than 5 feet above the floor. - 6.1.3.8.3 In no case shall the clearance between the bottom of the hand portable fire extinguisher and the floor be less than 4 inches. On 7/25/2022 (day one of the survey) starting at 9:10 AM, during a tour of the facility in the presence of the Director of Maintenance (DOM), the surveyor observed thirty three (33) portable fire extinguishers in various locations along the tour with the following; 1) [redacted] floor level, one ABC type fire extinguisher Facility Identification number (FI) #7 was located at the Commercial laundry room entrance doors. The surveyor measured and recorded the fire extinguisher was mounted at a height from the floor to the center of the pressure indicating needle 5 feet 3 inches. 2) [redacted] floor level, one ABC type fire extinguisher FI #29 located in the [redacted] room. The surveyor measured and recorded the fire extinguisher was mounted at a height from the floor to the center of the pressure indicating needle 5 feet 2-1/2 inches.	K 355	[redacted], fire extinguisher located in the resident TV room, fire extinguisher located in the corridor near the dining room, fire extinguisher located to the left of the sensory room, fire extinguisher located next to resident room [redacted] fire extinguisher located next to resident room #[redacted], and fire extinguisher located next to ADL room were all lowered so that the top of the fire extinguishers were below 5 feet from the floor. 2. The deficiencies cited under K355, if not corrected, would potentially present a fire and safety hazard to all residents, staff, and the public. 3. All maintenance staff were in-serviced on life safety and the importance of fire extinguishers being at the proper height. 4. The maintenance director or designee will monitor, by making rounds on a daily basis, that these deficiencies do not reoccur. They are also ensuring that the staff is adhering to all in services. All findings will be given to the quarterly quality assurance committee.	

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K 355	Continued From page 6 On 7/26/2022 (day two of the survey) starting at 10:24 AM, the surveyor observed ten (10) portable fire extinguishers in various locations along the tour in the [redacted] building with the following; 3) One ABC type fire extinguisher located in the corridor next to the Medical Records department. The surveyor measured and recorded the fire extinguisher was mounted at a height from the floor to the center of the pressure indicating needle 5 feet 4 inches. 4) One ABC type fire extinguisher located in the corridor next to the exit door #7. The surveyor measured and recorded the fire extinguisher was mounted at a height from the floor to the center of the pressure indicating needle 5 feet 3-1/2 inches. 5) One ABC type fire extinguisher located in the corridor next to the clean linen room. The surveyor measured and recorded the fire extinguisher was mounted at a height from the floor to the center of the pressure indicating needle 5 feet 3-1/2 inches. 6) One ABC type fire extinguisher located in the corridor near Resident room [redacted]. The surveyor measured and recorded the fire extinguisher was mounted at a height from the floor to the center of the pressure indicating needle 5 feet 3 inches. 7) One ABC type fire extinguisher located in the Resident [redacted] room [redacted]. The surveyor measured and recorded the fire extinguisher was mounted at a height from the floor to the center of the pressure indicating needle 5 feet 3 inches.	K 355		

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K 355	Continued From page 7 8) One ABC type fire extinguisher located in the corridor near the Dining room. The surveyor measured and recorded the fire extinguisher was mounted at a height from the floor to the center of the pressure indicating needle 5 feet 4 inches. 9) One ABC type fire extinguisher located in the corridor to the left of the [redacted] room. The surveyor measured and recorded the fire extinguisher was mounted at a height from the floor to the center of the pressure indicating needle 5 feet 3 inches. 10) One ABC type fire extinguisher located in the corridor next to Resident room [redacted]. The surveyor measured and recorded the fire extinguisher was mounted at a height from the floor to the center of the pressure indicating needle 5 feet 3 inches. 11) One ABC type fire extinguisher located in the corridor next to Resident room [redacted] The surveyor measured and recorded the fire extinguisher was mounted at a height from the floor to the center of the pressure indicating needle 5 feet 3 inches. 12) One ABC type fire extinguisher located in the corridor next to Average Daily Living (ADL) room. The surveyor measured and recorded the fire extinguisher was mounted at a height from the floor to the center of the pressure indicating needle 5 feet 2-1/2 inches. The DOM confirmed the findings at the time of observations. The Administrator was notified of the deficiency at the Life Safety Code exit conference on	K 355		

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K 355	Continued From page 8 7/26/2022 at approximately 1:30 PM. NFPA 10 NJAC 8:39 -31.1 (c).	K 355		
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies.	K 363		8/26/22

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K 363	Continued From page 9 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation on 07/25/2022, it was determined that the facility failed to ensure that corridor doors were able to resist the passage of smoke in accordance with the requirements of NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5. This deficient practice of not ensuring that room doors will close and latch restricts the ability of the facility to properly confine fire and smoke products and to properly defend occupants in place. This deficient practice was identified in 1 of 15 resident room doors observed and was evidenced by the following: 1. On 07/25/2022, during the building tour with the Director of Maintenance (DOM) at 10:45 AM, an inspection of Resident room [redacted] was performed. When the surveyor went to close the corridor door to the room, the door did not close into its frame as required. The surveyor observed that the door hit the frame and left an approximately one (1) inch gap at the top of the door. This condition would allow fire, smoke and poisonous gases to pass from the Residents room into the exit access corridor in the event of a fire. The findings were verified and confirmed by the	K 363	1. The door for resident room [redacted] was fixed, allowing it to properly close into the door frame and remove the 1 inch gap at the top of the door. 2. The deficiencies cited under K363, if not corrected, would potentially present a fire and safety hazard to all residents, staff, and the public. 3. All maintenance staff were in-serviced on life safety and the importance of resident room doors not having a gap. 4. The maintenance director or designee will monitor, by making rounds on a daily basis, that this deficiency does not reoccur. They are also ensuring that the staff is adhering to all in services. All findings will be given to the quarterly quality assurance committee.	

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K 363	Continued From page 10 DOM during the observations. The surveyor informed the Administrator of the findings at the Life Safety Code exit conference on 07/26'/2022 at approximately 1:30 PM. NJAC 8:39-31.1(c), 31.2(e) NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5.	K 363		
K 372 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING 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. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observations on 07/25/2022, it was determined that the facility failed to maintain the integrity of smoke barrier partitions for Two (2) of Seven (7) smoke barrier walls as evidenced by the following: On 07/25/2022 starting at 9:05 AM, with the facility's Director of Maintenance (DOM), a tour of the building which included the [redacted] and [redacted] floors of the Nursing Center and [redacted]	K 372	1a. Fireproof putty was installed around the 4 wires running through the barrier wall above the ceiling tile on 2nd floor, sealing off the hole. 1b. Fireproof putty was installed around the 2 cables and around the 5 cables running through the barrier wall above the ceiling tile on [redacted] floor, sealing off the holes.	8/26/22

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(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
K 372	Continued From page 11 [redacted]l Unit) was conducted. During the building tour the surveyor observed the following smoke barrier walls failed to maintain the 1/2 hour fire rated construction as required by code in the following locations, 1) At 9:44 AM, the surveyor observed on the Nursing Center [redacted] floor, above the ceiling tiles by the corridor double smoke doors, next to Resident room [redacted] an approximately 1" by 1" hole with 4 wires running through the smoke barrier wall. 2) At 11:21 AM, the surveyor observed on the Nursing Center[redacted] floor, above the ceiling tiles by the corridor double smoke doors next to Unit Managers office, had an approximately one 1 inch in diameter hole with 2 cables and one 1-1/2 inch in diameter hole with 5 cables running running through the smoke barrier wall. These penetrations were observed on both sides through the smoke barrier walls, indicating that it was not sealed closed to prevent smoke, fumes and fire from passing through to the other smoke compartment. The findings were verified and confirmed by DOM during the observations. The surveyor informed the Administrator of the findings at the Life Safety Code exit conference on 07/26/2022 at approximately 1:30 PM. Fire Safety Hazard. NJAC 8:39- 31.2(e)	K 372	2. The deficiencies cited under K372, if not corrected, would potentially present a fire and safety hazard to all residents, staff, and the public. 3. All maintenance staff were in-serviced on life safety and the importance of not having penetrations in smoke barrier walls. 4. The maintenance director or designee will monitor, by making rounds on a daily basis, that these deficiencies do not reoccur. They are also ensuring that the staff is adhering to all in services. All findings will be given to the quarterly quality assurance committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315244	A. BUILDING **01** B. WING _____	**07/26/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED CARE AT ABSECON	**1020 PITNEY ROAD** **ABSECON, NJ 08201**

(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
K 521	Continued From page 12	K 521		
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on observations and interview conducted on 07/25/2022, 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 4 of 15 resident bathroom exhaust systems as per the National Fire Protection Association (NFPA) 90A. This deficient practice was evidenced by the following: On 07/25/2022 (day one of survey) during the survey entrance at 8:42 AM, a request was made to the Director of maintenance (DOM) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments. Starting at 9:05 AM, in the presence of the facility's DOM, an inspection of 15 Resident rooms was performed. 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	K 521	1. The vents in resident rooms [redacted] were repaired and functioning properly. 2. The deficiencies cited under K521, if not corrected, would potentially present a fire and safety hazard to all residents, staff, and the public. 3. All maintenance staff were in-serviced on life safety and the importance of bathroom exhaust ventilation. 4. The maintenance director or designee will monitor, by making rounds on a daily basis, that these deficiencies do not reoccur. They are also ensuring that the staff is adhering to all in services. All findings will be given to the quarterly quality assurance committee.	8/26/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315244	A. BUILDING **01** B. WING _____	**07/26/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED CARE AT ABSECON	**1020 PITNEY ROAD** **ABSECON, NJ 08201**

(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
K 521	Continued From page 13 function properly in 4 of 15 resident bathrooms in the following locations: 1. At 9:16 AM, inside Resident room [redacted] bathroom, when tested the exhaust system did not function properly. At that time, the surveyor informed the DOM that the exhaust system did not function properly. The DOM told the surveyor that the exhaust system might have broken a belt. 2. At 9:49 AM, inside Resident room [redacted] bathroom, when tested the exhaust system did not function properly. 3. At 9:57 AM, inside Resident room [redacted] bathroom, when tested the exhaust system did not function properly. 4. At 11:27 AM, inside Resident room [redacted] bathroom, when tested the exhaust system did not function properly. All the bathrooms had no windows with an area that would open. The bathrooms would rely on mechanical ventilation. The DOM confirmed the findings at the time of the observation. The surveyor informed the Administrator of the findings at the Life Safety Code exit conference on 07/26/2022 at approximately 1:30 PM. NFPA 90A. NJAC 8:39- 31.2 (e).	K 521		