STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315292	A. BUILDING ______ B. WING ______	09/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLEWOOD ESTATES	**ONE APPLEWOOD DRIVE FREEHOLD, NJ 07728**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
F 000	INITIAL COMMENTS Survey Date: 9/21/22 Census: 40 Sample: 13 + 3 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 814 SS=D	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to properly dispose and maintain waste in 1 of 1 garbage dumpster areas as evidenced by the following: On 9/12/22 at 11:40 AM, the surveyor in the presence of the Food Service Director (FSD) inspected the garbage dumpster area which included two dumpsters on a concrete pad. The dumpster lids were closed however there was extensive debris including soiled gloves, plastic	F 814	1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice; these are the residents specified in the CMS-2567, Statement of Deficiencies. It is possible that all residents in the facility have the potential to be affected by the deficient practice.	9/30/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 10/05/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315292	A. BUILDING ______ B. WING ______	09/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLEWOOD ESTATES	ONE APPLEWOOD DRIVE FREEHOLD, NJ 07728

(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 814 Continued From page 1

cups, plastic bags, candy wrappers, shipping envelopes, papers, and discarded cigarettes on the concrete pad behind the dumpsters and in the grass adjacent to the dumpsters. The FSD stated the Housekeeping Department was responsible for maintaining the dumpster area.

On 9/13/22 at 1:20 PM, the surveyor interviewed the Housekeeping Supervisor (HS) who confirmed the Housekeeping Department was responsible for maintaining the garbage dumpster area. The HS stated that she did not see the garbage and debris around the back of the dumpster area and further stated, "it was an oversight." At this time, the surveyor requested a copy of the facility's policy related to maintaining and cleaning of the garbage area.

On 9/20/22 at 11:30 AM, the surveyor interviewed the License Nursing Home Administrator (LNHA) who confirmed the Housekeeping Department was responsible for maintenance of the dumpster area including cleanliness. The LNHA stated the facility had no policy regarding maintaining the garbage dumpster area.

On 9/21/22 at 11:31 AM, the LNHA in the presence of the Director of Nursing and the survey team acknowledged that the garbage dumpster area should be maintained free of garbage and cigarette debris.

NJAC 8:39-19.7(a)(b)

F 814

Completion Date: 9/30/2022

2. How the facility will identify other residents having the potential to be affected by the same deficient practice.

It is possible that all residents in the facility have the potential to be affected by the deficient practice.

Completion Date: 9/30/2022

3. What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur.

The compactor area was cleared, washed and scrubbed as a result of the deficient practice.
The Director of Facilities created an audit tool on 9/12/22 to reflect twice daily cleaning of the compactor area. The Housekeeping Manager will ensure that the scheduled housekeeping porter cleans the compactor area at 8am and 4pm daily 7 days a week. In the absence of the Housekeeping Manager, the Security Guard will monitor this cleaning process to ensure completion. Any issues and concerns will be bought up to the Housekeeping Manager who will then escalate it to the Director of Facilities if and when necessary.

Completion: 9/30/2022

4. How the facility will monitor its corrective actions to ensure that the

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315292	A. BUILDING ______ B. WING ______	**09/21/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLEWOOD ESTATES	**ONE APPLEWOOD DRIVE FREEHOLD, NJ 07728**

(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 814	Continued From page 2	F 814	deficient practice is being corrected and will not recur? The Housekeeping Manager will monitor completion of the audit tool logs. Results of the audit tool logs will be compiled, tracked, and trended to be presented to the QA committee on a quarterly basis starting with the January QAPI meeting. Completion Date: 1/11/2023	

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061343	A. BUILDING: ____ B. WING ____	09/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLEWOOD ESTATES	**ONE APPLEWOOD DRIVE FREEHOLD, NJ 07728**

(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) COMPLETE DATE
S 000	Initial Comments The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficieny and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, enforcement of licensure regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios as mandated by the State of New Jersey. This was evident for 3 of 42 shifts reviewed. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which	S 560	1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice; these are the residents specified in the CMS-2567, Statement of Deficiencies. It is possible that all residents in the facility have the potential to be affected by the deficient practice. Completion Date: 9/30/2022 2. How the facility will identify other residents having the potential to be affected by the same deficient practice.	9/30/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/05/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061343	A. BUILDING: ______ B. WING ______	09/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLEWOOD ESTATES	**ONE APPLEWOOD DRIVE FREEHOLD, NJ 07728**

(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) COMPLETE DATE
S 560	Continued From page 1 established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. During entrance conference on 9/12/22 at 11:11 AM, the surveyor provided the Licensed Nursing Home Administrator with the "Nursing Staffing Report" and requested two weeks of nursing staff for the time period of 8/28/22 through 9/10/22. As per the "Nurse Staffing Report" completed by the facility for the weeks of 8/28/22 to 9/3/22 and 9/4/22 to 9/10/22, the staffing to resident ratios that did not meet the minimum requirement of 1 CNA to 8 residents for the day shift as documented below: 8/28/22 had 4 CNAs for 39 residents on the day shift, required 5 CNAs. 8/31/22 had 4 CNAs for 38 residents on the day shift, required 5 CNAs. 9/10/22 had 4 CNAs for 37 residents on the day shift, required 5 CNAs.	S 560	It is possible that all residents in the facility have the potential to be affected by the deficient practice. Completion Date: 9/30/2022 3. What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur. Applewood Estates is actively recruiting for all C.N.A and nursing positions. Agency personnel is utilized as often as needed to fill vacant shifts. Incentives, bonuses, overtime pay, and other enticements are offered for existing and newly hired staff. Applewood's parent company, CentraState Medical Center has recently increased the starting rate of all C.N.A.'s to $24/hour to entice a larger population of full-time candidates. The Administrator created a tracking tool on 9/30/22 to track each shift's ratio according to resident census. The tracking tool will be completed by the Staffing Coordinator. The Administrator and/or Director of Nursing will review the completed tracking tool on a daily basis to ensure that the required staff to resident ratios are met for all three shifts, seven days a week. Completion: 9/30/2022 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur?	

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061343	A. BUILDING: ______ B. WING ______	09/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLEWOOD ESTATES	**ONE APPLEWOOD DRIVE FREEHOLD, NJ 07728**

(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) COMPLETE DATE
S 560	Continued From page 2 On 9/19/22 at 10:03 AM, the surveyor interviewed the Staffing Coordinator who stated she was aware of the staffing ratios for CNA. The Staffing Coordinator stated most of the time she was able to meet the staffing ratios and used Agency staff as needed for coverage. NJAC 8:39-5.1(a)	S 560	The Administrator and/or Director of Nursing will monitor the completion of the tracking tool. Results of the audit tool will be compiled, tracked, and trended to be presented to the QA committee on a quarterly basis starting with the January QAPI meeting. Completion Date: 1/11/2023	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315292	A. Building B. Wing	12/8/2022

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLEWOOD ESTATES	ONE APPLEWOOD DRIVE FREEHOLD, NJ 07728

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 F0814 Reg. # 483.60(i)(4) LSC	Correction Completed 09/30/2022	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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	
9/21/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061343 Y1	A. Building B. Wing Y2	12/8/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLEWOOD ESTATES	ONE APPLEWOOD DRIVE FREEHOLD, NJ 07728

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (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 S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 09/30/2022	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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 9/21/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315292	A. BUILDING 01 B. WING ______	09/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLEWOOD ESTATES	**ONE APPLEWOOD DRIVE** **FREEHOLD, NJ 07728**

(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 9/21/2022, Applewood Estates 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 Occupancy Applewood Estates is a two-story building that was built in January 1989. It is composed of Type II protected construction. The facility is divided into 4 smoke zones.	K 000		
K 291 SS=E	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 9/21/22, in the presence of facility management, it was determined that the facility failed provide a battery backup emergency light above 1 of 1 emergency generator's two transfer switches, independent of the building's electrical system and emergency generator in accordance with NFPA 101:2012 - 7.9, 19.2.9.1. This deficient practice was evidenced by the following: During the survey entrance on 9/21/22 at 9:15 AM, the surveyor requested the Director of Facilities (DOF) to provide a copy of the facility's	K 291	1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice; these are the residents specified in the CMS-2567, Statement of Deficiencies. It is possible that all residents in the facility have the potential to be affected by the deficient practice. Completion Date: 9/30/2022 2. How the facility will identify other	9/30/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/05/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315292	A. BUILDING 01 B. WING ______	09/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLEWOOD ESTATES	**ONE APPLEWOOD DRIVE** **FREEHOLD, NJ 07728**

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K 291	Continued From page 1 layout which identified the various rooms and if the facility had an emergency generator. The DOF responded, yes we have a generator. During the building tour with the facility DOF at approximately 10:17 AM, the surveyor inspected the inside of the Main Electrical room where the emergency generator's two (2) transfer switches were located. At this time, the surveyor asked the DOF if there was a battery back-up emergency light for the transfer switch. The DOF looked around and stated, no. The DOF confirmed the findings at the time of observations. The Licensed Nursing Home Administrator was notified of the finding at the Life Safety Code exit conference on 9/21/22 at approximately 1:55 PM. NJAC 8:39-31.2(e) NFPA 101:2012 - 19.2.9.1, 7.9	K 291	residents having the potential to be affected by the same deficient practice. It is possible that all residents in the facility have the potential to be affected by the deficient practice. Completion Date: 9/30/2022 3. What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur. An emergency 1-1/2 hour battery backup light was installed on 9/23/22 over both transfer switches in the main electrical room. The Maintenance Technician will inspect the emergency battery backlight on a monthly basis for six months to ensure proper functionality. Results of the inspection will be documented on an audit tool. Completion: 9/30/2022 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur? The Maintenance Technician will inspect the emergency battery backlight on a monthly basis for six months to ensure proper functionality. All issues and concerns will be bought forth to the Director of Facilities. Results of the audit tool logs will be compiled, tracked, and trended to be presented to the QA	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315292	A. BUILDING **01** B. WING ______	**09/21/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLEWOOD ESTATES	**ONE APPLEWOOD DRIVE** **FREEHOLD, NJ 07728**

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K 291	Continued From page 2	K 291	committee on a quarterly basis starting with the January QAPI meeting. Completion Date: 9/30/22	
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:	K 321		9/30/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315292	A. BUILDING **01** B. WING ___	**09/21/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLEWOOD ESTATES	**ONE APPLEWOOD DRIVE** **FREEHOLD, NJ 07728**

(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 321	Continued From page 3 Based on observation and review of facility documentation on 9/21/22, 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. This deficient practice was identified and could affect 2 of 4 smoke zones. The evidence was as followed: During the survey entrance 9/21/2022 at 9:15 AM, the surveyor requested the Director of Facilities (DOF) to provide a copy of the facility's layout which identified the various rooms and smoke compartments in the facility. During the building tour with the facility DOF at approximately 11:05 AM, the surveyor inspected the inside of the second floor Orchard room. The surveyor observed that the fire rated corridor door leading into the room had no means to self-close the door into its frame. The surveyor observed inside the room 42 cardboard boxes filled with medical equipment, gloves, and multiple combustible products. The room was larger than 50 square feet and the door failed to self-close into its frame as required by code. A review of an evacuation diagram posted in the area identified the room was in the primary exit access route to reach an exit in the event of a fire. This condition would allow fire, smoke, and poisonous gases to pass from the room into the exit access corridor in the event of a fire.	K 321	1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice; these are the residents specified in the CMS-2567, Statement of Deficiencies. It is possible that all residents in the facility have the potential to be affected by the deficient practice. Completion Date: 9/30/2022 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. It is possible that all residents in the facility have the potential to be affected by the deficient practice. Completion Date: 9/30/2022 3. What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur. A mechanical door closer was installed on 9/21/22 to the existing fire rated doors of the Orchard Room and Storage Room. The mechanical door closer was tested to close upon opening and latch into frame. The Maintenance Technician will inspect the mechanical door closer on a monthly basis for six months for proper functionality. Results of the inspection will be documented on an audit tool. Completion: 9/30/2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315292	A. BUILDING 01 B. WING ______	09/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLEWOOD ESTATES	ONE APPLEWOOD DRIVE FREEHOLD, NJ 07728

(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 321	Continued From page 4 The DOF confirmed the findings at the time of observations. The Licensed Nursing Home Administrator was notified of the finding at the Life Safety Code exit conference on 9/21/22 at approximately 1:55 PM. NJAC 8:39-31.2 (e) Life Safety Code 101	K 321	4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur? Doors will be added to the Annual Smoke and Fire Door inspection list which is performed by The Contractor starting with the next scheduled inspection which is on 10/24/22. The Maintenance Technician will inspect the mechanical door on a monthly basis for six months to ensure proper functionality. All issues and concerns will be bought forth to the Director of Facilities. Results of the audit tool logs will be compiled, tracked, and trended to be presented to the QA committee on a quarterly basis starting with the January QAPI meeting. Completion Date: 9/30/2022	
K 351 SS=E	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING 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. 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. In hospitals, sprinklers are not required in clothes	K 351		12/2/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315292	A. BUILDING **01** B. WING ____________	**09/21/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLEWOOD ESTATES	**ONE APPLEWOOD DRIVE** **FREEHOLD, NJ 07728**

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K 351	Continued From page 5 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. 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) This REQUIREMENT is not met as evidenced by: Based on observations and interview on 9/21/22, in the presence of facility management, it was determined the facility failed to provide proper fire sprinkler coverage to all areas of the facility as required by National Fire Protection Association (NFPA) 13 for Installation of Sprinkler Systems. This deficient practice was identified and could affect 1 of 4 smoke zones. The evidence was as followed: Reference #1: National Fire Protection Association (NFPA) 13 Standard for the Installation of Sprinkler Systems. Installation Requirements: -8.8.4.1.1 Unobstructed Construction. -8.8.4.1.1.1 Under unobstructed construction, the distance between the sprinkler deflector and the ceiling shall be a minimum on 1 inch (25.4 mm) and a maximum of 12 inches (305 mm) throughout the area of coverage of the sprinkler. During the survey entrance 9/21/22 at 9:15 AM, the surveyor requested the Director of Facilities (DOF) to provide a copy of the facility's layout which identified the various rooms and smoke compartments in the facility. During a tour of the building with the DOF at approximately 10:20 AM, the surveyor inspected	K 351	1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice; these are the residents specified in the CMS-2567, Statement of Deficiencies. It is possible that all residents in the facility have the potential to be affected by the deficient practice. Completion Date: 12/2/2022 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. It is possible that all residents in the facility have the potential to be affected by the deficient practice. Completion Date: 12/2/2022 3. What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur. The Contractor was contracted on 9/27/22 to design for two additional upright sprinklers and schedule	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315292	A. BUILDING 01 B. WING ______	09/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLEWOOD ESTATES	**ONE APPLEWOOD DRIVE** **FREEHOLD, NJ 07728**

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K 351	Continued From page 6 the inside of the first-floor Mechanical room. The surveyor observed two (2) down pendant type fire sprinklers; this type of fire sprinkler heads were used in the application where there was a ceiling tile or wallboard type ceiling. At this time, the surveyor in the presence of the DOH, used a construction tape measure to record the distance from the sprinkler to the decking above. The down pendant heads were five (5) feet down form the metal decking above. Code required up-rite fire sprinkler heads to be within twelve (12) inches of a room's ceiling. The DOF confirmed the findings at the time of observations. The Licensed Nursing Home Administrator was notified of these findings at the Life Safety Code exit conference on 9/21/22 at approximately 1:55 PM. Fire Safety Hazard. NJAC 8:39-31.1(c), 31.2(e) NFPA 13.	K 351	installation. Installation dates are as follows: 11/28, 11/29, 12/1, and 12/2/22. The additional upright sprinklers, once installed, will be added to the quarterly inspections performed by The Contractor. Completion: 12/2/2022 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur? The additional upright sprinklers will be added to the quarterly inspections performed by The Contractor. All issues and concerns will be bought forth to the Director of Facilities immediately. Results of the quarterly inspections will be compiled, tracked, and trended to be presented to the QA committee on a quarterly basis starting with the January QAPI meeting. Completion Date: 12/2/2022	
K 918 SS=E	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing 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	K 918		11/15/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315292	A. BUILDING 01 B. WING ______	09/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLEWOOD ESTATES	ONE APPLEWOOD DRIVE FREEHOLD, NJ 07728

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K 918	Continued From page 7 critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 9/21/22 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 generator was installed in accordance with the requirements of NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. This deficient practice could affect all residents and was evidenced by the following:	K 918	1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice; these are the residents specified in the CMS-2567, Statement of Deficiencies. It is possible that all residents in the facility have the potential to be affected by the deficient practice.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315292	A. BUILDING **01** B. WING ______	**09/21/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLEWOOD ESTATES	**ONE APPLEWOOD DRIVE** **FREEHOLD, NJ 07728**

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K 918	Continued From page 8 During the survey entrance on 9/21/22 at 9:15 AM, the surveyor asked the Director of Facilities (DOF) if the facility had an emergency generator. The DOF responded, yes we have one. During the building tour with the facility DOF at approximately 10:17 AM, the surveyor inspected the inside of the Generator room where the emergency generator was located. At this time, the surveyor asked the DOF where the remote emergency shut off for the generator was located. The DOF informed the surveyor the facility did not have a remote emergency shut off for the generator. The surveyor observed that the emergency shut off was located on the generator's control panel. The DOF confirmed the findings at the time of observations. The Licensed Nursing Home Administrator was notified of the finding at the Life Safety Code exit conference on 9/21/22 at approximately 1:55 PM. NJAC 8:39-31.2(e), 31.2(g) NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1.	K 918	Completion Date: 11/15/2022 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. It is possible that all residents in the facility have the potential to be affected by the deficient practice. Completion Date: 11/15/2022 3. What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur. Generator technician from The Contractor and electrician from the other Contractor completed installation of the remote emergency stop button located immediately outside the generator room on 9/23/22. The Maintenance Technician will inspect the remote emergency stop button on a monthly basis for six months to ensure proper functionality. Results of the inspection will be documented on an audit tool. Completion: 11/15/2022 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur? The emergency stop button will be monitored and audited by The Contractor s generator technician during	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315292	A. BUILDING **01** B. WING ______	**09/21/2022**

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K 918	Continued From page 9	K 918	their existing quarterly inspections starting on the November scheduled visit. The Maintenance Technician will inspect the remote emergency stop button on a monthly basis for six months to ensure proper functionality. All issues and concerns will be bought forth to the Director of Facilities. Results of the audit tool logs will be compiled, tracked, and trended to be presented to the QA committee on a quarterly basis starting with the January QAPI meeting. Completion Date: 11/15/2022	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315292	A. Building 01 - MAIN BUILDING 01 B. Wing	12/8/2022

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLEWOOD ESTATES	ONE APPLEWOOD DRIVE FREEHOLD, NJ 07728

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 Reg. # NFPA 101 LSC K0291	Correction Completed 09/30/2022	ID Prefix Reg. # NFPA 101 LSC K0321	Correction Completed 09/30/2022	ID Prefix Reg. # NFPA 101 LSC K0351	Correction Completed 12/02/2022
ID Prefix Reg. # NFPA 101 LSC K0918	Correction Completed 11/15/2022	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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	
9/21/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO