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 _____	C 11/27/2024

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 000	INITIAL COMMENTS Complaint #: NJ175694 Survey Date: 11/27/24 Census: 31 Sample: 12 + 2 closed records 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 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;	F 880		12/16/24

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

Electronically Signed | 12/17/2024

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 _____	C 11/27/2024

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 880	Continued From page 1 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 880		

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 _____	C 11/27/2024

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 880	Continued From page 2 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to maintain proper infection control practices by; a) performing hand hygiene during medication administration and b) donning (putting on) the appropriate Personal Protective Equipment (PPE) prior to entering NJ Ex Order 26.4b1 room. This deficient practice was identified for 1 of 6 residents observed during medication administration (Resident #20) and 1 of 3 residents observed for NJ ex order 26.4b1 (Resident #28), and was evidenced by the following: 1. On 11/24/24 at 9:45 AM, the surveyor observed the Licensed Practical Nurse (LPN #1) conduct medication administration. After administering medications to Resident #26, LPN #1, without performing hand hygiene and still holding the cup of water which Resident #26 NJ ex order 26.4b1 Resident #20. LPN #1 proceeded to adjust Resident #20's blanket and brushed her hand overtop the resident's hair while informing Resident #20 that she would administer their NJ ex order 26.4b1. LPN #1 then proceeded back to the medication cart, located in the hallway outside the resident's door, and disposed of Resident #26's used cup of water. LPN #1, without performing hand hygiene, documented in the computer on of the medication cart; then accessed the medication cart drawer to obtain Resident #20's NJ ex order 26.4b1. LPN #1, still with no performed hand hygiene,	F 880	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. Residents were not adversely affected by this finding. Immediately following the surveyor's findings, the Infection Preventionist in-serviced LPN #1 about adherence to proper hand hygiene protocol during medication administration practices, before and after resident care, and donning and doffing appropriate Personal Protective Equipment in accordance with "Hand Hygiene Policy." The Infection Preventionist also educated LPN #2 and LPN #3 about "Policy and Procedure, Enhanced Barrier Precautions (EBP)"and the requirement to don a gown prior to and during wound care. 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 community may potentially be affected by the deficient practice. 3. What measures will be put into place or systemic changes made to ensure that	

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 _____	C 11/27/2024

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 880	Continued From page 3 NJ ex order 26.4b1 and proceeded to Resident #20's bedside where she donned disposable gloves and placed the resident's NJ Ex Order 26.4b1 on the resident. LPN #1 then doffed (took off) her gloves and without performing hand hygiene, placed the NJ Ex Order 26.4b1 on the resident to obtain the resident's NJ ex order 26.4b1. LPN #1 then removed the NJ ex order 26.4b1 NJ ex order 26.4b1 and brought the machine back out to the hallway. Without performing hand hygiene, LPN #1 then donned clean gloves and disinfected the machine using disinfecting wipes. LPN #1 then disposed of the wipe, doffed and disposed the gloves and then performed hand hygiene with alcohol-based hand rub (ABHR). On 11/24/24 at 10:05 AM, the surveyor interviewed LPN #1 who confirmed that she "forgot" to perform hand hygiene in between residents during medication administration and that it was important for infection control purposes. On 11/26/24 at 10:02 AM, the surveyor interviewed the US FOIA (B) (6), who stated that the general expectation was to perform hand hygiene with soap and water or use ABHR before starting a procedure and in between residents. The US FOIA (b)(6) further stated that hand hygiene was to be performed in between glove changes always. The US FOIA (b)(6) confirmed LPN #1 should have performed hand hygiene after administering Resident #26's NJ ex order 26.4b1 before touching Resident #20; prior to accessing the medication cart; and prior to donning and after doffing gloves. On 11/27/24 at 9:41 AM, the US FOIA (B) (6)	F 880	the deficient practice would not recur. The Infection Preventionist educated all nurses about adherence to proper hand hygiene protocol in accordance with the "Hand Hygiene Policy" including during medication administration practices, before and after resident care, and donning and doffing appropriate Personal Protective Equipment. The Infection Preventionist also in-serviced all nurses about "Policy and Procedure, Enhanced Barrier Precautions (EBP)" including the requirement to don a gown prior to and during wound care. In addition, the Infection Preventionist will arrange that a hand hygiene and EBP competency is performed by each nurse to demonstrate effective return demonstration. Going forward, the Infection Preventionist will also re-educate all nurses about these two policies and obtain a new competency of both practices from each nurse on a quarterly basis instead of semi-annually. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur? The Infection Preventionist will conduct four audits weekly for four months to monitor nurse adherence to both proper hand hygiene protocol and EBP. The audits will be rotated on the three shifts and weekends, as necessary, to capture all nurses. The results of the audits and any concerns will be reported to the Administrator and Director of Nursing	

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 _____	C 11/27/2024

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 880	Continued From page 4 US FOIA (B) (6), in the presence of the survey team, the US FOIA (B) (6), the US FOIA (B) (6), and the US FOIA (B) (6) acknowledged that proper hand hygiene was to be performed by all nurses while administering medications. 2. On 11/24/24 at 11:32 AM, the surveyor reviewed Resident #28's electronic medical record which indicated the following: A review of the Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnosis which included but was not limited to; NJ Ex Order 26.4b1 [redacted] A review the most recent comprehensive Minimum Data Set (MDS), an assessment tool dated NJ ex order 26.4b1, indicated the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, which indicated a NJ ex order 26.4b1. A further review in Section M NJ ex order 26.4b1" indicated the resident NJ ex order 26.4b1 [redacted] A review of the individualized comprehensive care plan (ICCP) included a focus area dated NJ ex order 26.4b1, NJ ex order 26.4b1 [redacted] to include a NJ ex order 26.4b1 [redacted]. Interventions included to provide NJ ex order 26.4b1 [redacted]. A review of the NJ ex order 26.4b1 Treatment Administration Record (TAR) included a	F 880	upon completion for appropriate follow-up. In addition, the audit results will be compiled, tracked, and trended in a report that will be presented to the QAPI committee quarterly, starting with the January meeting. The four weekly audits of each practice will be discontinued when 100% compliance is achieved for four consecutive months. Afterwards, the Infection Preventionist will complete the same audit of each practice at least twice weekly on an ongoing basis, as part of her ongoing infection prevention and control surveillance.	

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 _____	C 11/27/2024

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 880	Continued From page 5	F 880		

NJ ex order 26.4b1, to NJ ex order 26.4b1 and NJ ex order 26.4b1 NJ ex order 26.4b1

On 11/26/24 at 12:24 PM, the surveyor observed LPN #2 and LPN #3 perform NJ ex order 26.4b1 for Resident #28. On the resident's room door was a sign which indicated NJ ex order 26.4b1 that NJ ex order 26.4b1 . The surveyor observed a PPE bin outside the resident's door which contained gloves and gowns. The surveyor observed LPN #2 and LPN #3 preparing and gathering supplies for NJ ex order 26.4b1 donned gloves prior to entering the resident's room, but did not don a gown. LPN #2 and LPN #3 then performed NJ ex order 26.4b1 on Resident #28 without wearing a gown.

On 11/26/24 at 1:04 PM, LPN #2 and LPN #3 completed NJ ex order 26.4b1 and exited the resident's room. At that time, the surveyor interviewed both LPNs, who confirmed that a gown was required as part of the PPE needed to be worn during NJ ex order 26.4b1 and confirmed that the EBP sign on the resident's door indicated that as well. LPN #2 and LPN #3 both acknowledged that they forgot to put on a gown as required prior to and during the NJ ex order 26.4b1 .

On 11/26/24 at 1:46 PM, the surveyor interviewed the US FOIA (b), who confirmed Resident #28 had a NJ ex order 26.4b1 and that NJ ex order 26.4b1 would be classified as NJ ex order 26.4b1 and required the

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 _____	C 11/27/2024

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 880	Continued From page 6 person providing the care to wear a gown and gloves. On 11/27/24 at 9:41 AM, the [US FOIA (B) (6)], in the presence of the survey team, the [US FOIA (B) (6)], the [US FOIA (B) (6)], and the [US FOIA (B) (6)], acknowledged that the LPNs should have worn a gown during wound care since the resident was [NJ Ex Order 26.4b1] A review of the facility's "Infection Control General Guidelines for All Nursing Procedures" policy revised September 2019, included;...4. in most situations, the preferred method of hand hygiene is with an alcohol-based hand rub. If hands are not visibly soiled, use an alcohol-based hand rub containing 60-95% ethanol or isopropanol for all the following situations: a. before and after direct contact with residents; b. before donning sterile gloves; c. before performing any non-surgical invasive procedures; d. before preparing or handling medications; e. before handling clean or soiled dressings, gauze pads, etc.; f. before moving from a contaminated body site to a clean body site during resident care; g. after contact with a resident's intact skin; h. after handling used dressings, contaminated equipment, etc.; i. after contact with objects (e.g., medical equipment) in the immediate vicinity of the resident; and j. after removing gloves; 5. Wear personal protective equipment as necessary to prevent exposure to spills or splashes of blood or body fluids or other potentially infectious materials; 6. In addition to these general guidelines, refer to procedures for any specific infection control precautions that may be warranted... A review of the facility's "Enhanced Barrier Precautions" policy revised 3/25/24, included;...Enhanced Barrier Precautions expand	F 880		

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 _____	C 11/27/2024

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 880	Continued From page 7 the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs (multi-drug resistant organisms) to staff hands and clothing. The policy further included, "for residents for whom EBP are indicted, EBP is employed when performing the following high contact resident care activities:...wound care: any skin opening requiring a dressing...	F 880		
F 919 SS=F	NJAC 8:39 - 19.4(a); 27.1(a) Resident Call System CFR(s): 483.90(g)(1)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 11/25/24, in the presence of the US FOIA (B) (6) [redacted], it was determined that the facility failed to ensure that the resident call bell system properly functioned by a.) ensuring the call bell system volume was set to a level to be heard and b.) devices used to identify call bell notifications were functioning properly. This deficient practice had the potential to affect all residents and was evidenced by the following: On 11/25/24 at 1:08 PM, the surveyor observed when the call bell was tested for Resident Room	F 919	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. There was no evidence that residents were adversely affected by this finding. Immediately following the surveyor's findings, it was determined that the designated beeper for Resident Suites #229 and #231 was not tested at the time	12/16/24

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 _____	C 11/27/2024

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 919	Continued From page 8 #229, there was no audible notification of the call. There was visual notification on the computer screen at the nurse's station and by light outside of the resident room. At the time of the observation, the surveyor interviewed the US FOIA (B) (6), who confirmed that there was no audible notification and stated that there should have been audible notification at the nurse's station. The US FOIA (B) (6) stated that the aides also carried pagers that identified when a call bell had been activated. The US FOIA (B) (6) then approached the nurse on duty and asked if they had a pager for the call bell system. The nurse stated that they did and proceeded to check their pockets. The nurse was unable to locate the pager in their pocket but was able to find it locked in the top drawer of the medication cart. The US FOIA (B) (6) retrieved the pager to show the surveyor that the pager received notifications from the call bell system. The US FOIA (B) (6) was unable to show that the pager received notifications from the call bell that was tested and stated that the pager was on vibrate mode. The US FOIA (B) (6) was unsure of why the pager was not receiving notifications. On 11/25/24 at 1:24 PM, the surveyor observed when the call bell was tested for Resident Room #231, there was no audible notification of the call bell system. The US FOIA (B) (6), while carrying the call bell pager, confirmed that they NJ ex order 26.4b1 [redacted]. On 11/25/24 at 1:31 PM, the surveyor observed when the call bell was tested for Resident Room #226, there was no audible notification of the call bell system. However, the aide on that unit received notification by pager of the call bell activation.	F 919	of the survey to verify proper functionality. It was subsequently identified that the tested beeper in question was programmed for another wing of resident suites in skilled nursing and was not set-up as the designated beeper for rooms #229 and #231. The communication system relays signals to specific devices that are programmed according to designated zones within the skilled nursing neighborhood. The designated beeper for Suites #229 and 231 was subsequently tested and was working properly, i.e., call signals were received for these suites. The volume on the call system screen in a team, work area was turned up so that the alerts are audible to team members who intermittently work there. The audible alert is a supplemental measure to our decentralized call system consisting of beepers, lights over the suite doors, and lights on the call panel to indicate the presence of resident calls. All team members who were working that day were immediately educated about the requirement to maintain an audible volume to the alerts on the call system screen in the work area. 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 if the communication system is not operational.	

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 _____	C 11/27/2024

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 919	Continued From page 9 On 11/25/24 at 2:00 PM, the surveyor interviewed the [redacted] who stated that they were able to figure out the problem with the audible notification at the nurse's station; that the volume had been turned down at the main computer. The [redacted] stated he turned the volume up so that it could be heard. NJAC 8:39-31.2(e), 31.8(c)9	F 919	3. What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur. All team members were educated about the requirement to maintain an audible volume to the alerts on a call system screen in the team, work area. Signage was also affixed next to the screen in the team, work area that states that the call alerts must be always be audible. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur? The Director of Nursing/Charge Nurse designee will complete an audit four times weekly on each shift including one weekend day to monitor that the alerts on the call system screen in the team, work area are audible. The audits will be conducted for two months and the results will be reported to the QAPI Committee on a quarterly basis starting with the meeting in January. This audit will be discontinued when 100% compliance is achieved for two consecutive months. Subsequently, audits will be done periodically as determined by the QAPI Committee.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315292 Y1	A. Building B. Wing Y2	2/5/2025 Y3

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 F0880	Correction	ID Prefix F0919	Correction	ID Prefix	Correction
Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. # 483.90(g)(1)(2)	Completed	Reg. #	Completed
LSC	12/16/2024	LSC	12/16/2024	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
11/27/2024	☐ 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 _____	**11/27/2024**

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		
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 11/25/2024 and 11/26/2024. 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 Built in January 1989, Applewood Estates is a two-story building featuring Type II protected construction. The facility houses independent living units on the first floor and a healthcare unit on the second floor. The surveyed healthcare unit on the second floor was divided into two smoke zones.	K 000		
K 324 SS=F	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2	K 324		12/16/24

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

Electronically Signed | 12/18/2024

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 _____	**11/27/2024**

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 324	Continued From page 1 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on record review and interview on 11/26/2024 in the presence of the US FOIA (B) (6) [redacted], it was determined that the facility failed to ensure that cooking equipment was maintained in accordance with NFPA 101:2012 Edition, Sections 9.2.3 and NFPA 96. This deficient practice had the potential to affect all residents and was evidenced by the following: A record review on 11/26/2024 revealed the semi-annual kitchen suppression system inspections that were conducted on 3/20/2024 and 09/26/2024 both indicated "tech unable to test building fire alarm activation, fuel shutoff, electrical appliance shutoff or fan shutoff" and "Tech is consistently unable to perform full inspection of system due to time of inspection and not having a site contact available to either place system on test or bypass panel".	K 324	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. Residents were not adversely affected by this finding. Immediately following the surveyor's findings, the Plant Operations Director called the fire protection vendor to schedule an inspection of the audible system for the Ansul system. 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	

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 _____	**11/27/2024**

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 324	Continued From page 2 The semi-annual inspection conducted on 3/20/2024 indicated a notification of deficiencies but still marked the systems as in compliance with NJAC 5:70-3. The semi-annual inspection conducted on 9/26/2024 did not indicate a notification of deficiencies although it did indicate that a full inspection was not performed and still marked the system as in compliance with NJAC 5:70-3. In an interview at the time, the US FOIA (B) (6) stated that he contacted the kitchen suppression system inspection company. The US FOIA (B) (6) stated that he does not know where the disconnect with the inspections came but he would get it figured out right away. The US FOIA (B) (6) was informed of the deficient practice at the Life Safety Code exit conference on 11/26/2024 at 1:00 PM. N.J.A.C 8:39-31.2(e) NFPA 96	K 324	the deficient practice. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur. The fire protection vendor conducted an inspection of the audible system on 12/16/24. The Plant Operations Director was on site for this inspection. For all future inspections, the Plant Operations Director or the designee will be on site during the semiannual inspection to ensure that all audibles, and strobes are tested as required by the NFPA regulation. A preventative maintenance checklist was created to identify the timeframes when regulatory inspections are due. Completion date and results of the inspection will be documented on the checklist and tracked on an audit tool for six months and reviewed by the Plant Operations Director. Evidence of the inspection report from 12/16/24 is attached. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur? The results of the semiannual inspection of the audible system for the Ansul system will be documented on the checklist and audited quarterly to assess accuracy and completion. The results of the audits will be documented, and all issues and concerns will be brought forth to the Plant Operations Director. Results of the audit	

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 _____	**11/27/2024**

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 324	Continued From page 3	K 324	tool logs will be compiled, tracked, and trended to be presented to the QA committee starting with the January QAPI meeting.	
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 interview on 11/26/2024 in the presence of the [US FOIA (B) (6)] [redacted] it was determined that the facility failed to ensure that Class K portable fire extinguishers were provided with the required instructional placard in accordance with NFPA 101:2012 Edition, Sections 9.7.4, NFPA 10:2010 Edition, Sections 5.5.5.3 and A 5.5.5.3. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 10:20 AM revealed the Class K fire extinguisher in the kitchen was not provided with an instruction placard stating the fire protection system shall be actuated prior to using the portable fire extinguisher. In an interview at the time, the [US FOIA (B) (6)] confirmed the observation. The facility's [US FOIA (B) (6)] was informed of the deficient practice at the Life Safety Code exit conference on 11/26/2024 at 1:00 PM.	K 355	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. Residents were not adversely affected by this finding. Immediately following the surveyor□s findings, the Plant Operations Director relocated the instruction placard to the location of the Class K fire extinguisher and educated the kitchen staff on the appropriate placement. The fire protection vendor supplied the facility with a strong adhesive placard on 12/16/24 to help prevent future dislocations. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice.	12/16/24

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 _____	**11/27/2024**

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 355	Continued From page 4 N.J.A.C 8:39-31.2(e) NFPA 10	K 355	It is possible that all residents in the facility have the potential to be affected by the deficient practice. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur. The maintenance technician will conduct monthly inspection for six months of Class K fire extinguisher placard location to ensure proper placement. Results of the inspections will be documented on an audit tool and reviewed by the Plant Operations Director. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur? The results of the inspections will be documented, and all issues and concerns will be brought forth to the Plant Operations Director. 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.	
K 916 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Alarm Annunciator A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is	K 916		12/13/24

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 _____	11/27/2024

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 916	Continued From page 5 hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator. 6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 11/26/2024 in the presence of the US FOIA (B) (6) [redacted] it was determined that the facility failed to ensure that the generator was provided with a remote generator annunciator panel that was in accordance with NFPA 99 Sections 6.4.2.2.6, 6.4.1.1.17.5 - 6.4.1.1.17.5. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 10:45 AM revealed the generator annunciator panel located at the nurses station was not provided with individual visual signals that indicate when the battery charger is malfunctioning, low lubricating oil pressure, low water temperature, excessive water temperature, low fuel, overcrank or overspeed. Additionally, a lamp test switch(es) to test the operation of all alarm lamps was not provided. In an interview at the time, the US FOIA (B) (6) confirmed the observations. The facility's US FOIA (B) (6)r was informed of the deficient practice at the Life Safety Code exit conference on 11/26/2024 at 1:00 PM. N.J.A.C 8:39-31.2(e) NFPA 99	K 916	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. Residents were not adversely affected by this finding. Immediately following the surveyor□s findings, the Plant Operations Director contacted the generator company to review the annunciator in place for any available upgrades and installation of lamp test switches to test operation of all alarm lamps. 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. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur. The generator company scheduled a review of the existing annunciator panel on 12/13/24 to assess any available upgrades based on the configuration of	

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 _____	**11/27/2024**

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 916	Continued From page 6	K 916	the generator and the installation of lamp test switches. The assessment determined that an electrician is required to revisit the facility and install additional wires from the generator to the panel. Evidence of the generator company□s findings report will be attached upon completion. The Plant Operations Director or designee will conduct a monthly lamp test inspection to ensure functionality. Results of the inspection will be documented on an audit tool monthly for six months and reviewed by the Plant Operations Director. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur? Based upon the findings of the generator company, any available sensors and/or switches that can be applied to the annunciator panel will be connected to the annunciator panel or if needed, change the annunciator panel dependent on the availability of such sensors and wiring as designed within the generator. The results of the monthly lamp test inspections will be documented on an audit log, and all issues and concerns will be brought forth to the Plant Operations Director. Results of the audit logs will be compiled, tracked, and trended to be presented to the QA committee on a quarterly basis starting with the January QAPI meeting.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101	K 918		12/9/24

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 _____	**11/27/2024**

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 918	Continued From page 7 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 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 record review and interview on 11/26/2024 in the presence of the US FOIA (B) (6)	K 918	1. How the corrective action will be accomplished for those residents found to	

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 _____	**11/27/2024**

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 918	Continued From page 8 US FOIA (B) (6), it was determined that the facility failed to ensure that the maintenance and testing of the generators was in accordance with NFPA 99 Sections 6.4.4, 6.5.4, 6.6.4, NFPA 110, NFPA 111 and NFPA 70. This deficient practice had the potential to affect all residents and was evidenced by the following: A record review revealed quarterly emergency generator maintenance was conducted on 2/5/2024 and 5/14/2024 and a major service was conducted on 11/11/2024. In an interview at the time, the US FOIA (B) (6) confirmed that there was no other documentation available regarding the requirement of having the transfer switch on an annual maintenance program consisting of 1 major service and 3 quarterly inspections. The US FOIA (B) (6) stated that the missing quarterly inspection (Q3), was during the transition to new ownership. The facility's US FOIA (b)(6) was informed of the deficient practice at the Life Safety Code exit conference on 11/26/2024 at 1:00 PM. N.J.A.C 8:39-31.2(e) NFPA 110, 111, 70	K 918	have been affected by the deficient practice; these are the residents specified in the CMS-2567, Statement of Deficiencies. Residents were not adversely affected by this finding. Immediately following the surveyor□s findings, the Plant Operations Director confirmed that a contract with the generator company was put in place in November and that the major quarterly generator inspection was conducted on 11/11/24. 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. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur. The contract with the generator company is in place to provide the facility with one A (major) service and three B (minor) services annually. A preventative maintenance checklist was created to identify the timeframes when regulatory inspections are due. Completion date and results of the one major and three minor quarterly generator inspections will be documented on the checklist and tracked on an audit tool for six months and reviewed by the Plant Operations Director.	

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 _____	**11/27/2024**

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 918	Continued From page 9	K 918	4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur? The results of the quarterly generator inspections will be documented on the checklist and audited monthly to assess accuracy and completion. The results of the audits will be documented, and all issues and concerns will be brought forth to the Plant Operations Director. Results of the audit tool logs will be compiled, tracked, and trended to be presented to the QA committee starting with the January QAPI meeting.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315292 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	2/5/2025 Y3

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	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0324	12/16/2024	LSC K0355	12/16/2024	LSC K0916	12/13/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0918	12/09/2024	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
11/27/2024	☐ YES ☐ NO