STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315499	A. BUILDING _____ B. WING _____	C 02/13/2025

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F 000	INITIAL COMMENTS Complaint #: NJ165086, NJ175960 and NJ179408 Survey Date: 2/7/25 - 2/13/25 Census: 101 Sample: 21 + 2 Closed 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 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all	F 550		3/28/25

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

Electronically Signed | 03/07/2025

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.

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F 550	Continued From page 1 residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. 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 ensure that residents were served their meals in a manner that promotes respect and dignity for 2 residents (Resident #32 and #42) observed during a lunch meal service on 1 of 4 units (Skilled 2). This deficient practice was evidenced by the following: 1.) On 2/10/25 at 12:00 PM, the surveyor observed the lunch meal service in the [NJ Exec Order 26.4b] nursing unit dining room. Resident #32 was seated in a [NJ Exec Order 26.4b1]) chair ([NJ Exec Order 26.4b1]) at a table with two other residents. At 12:38 PM, the surveyor observed Licensed Practical Nurse (LPN) #1 standing over Resident	F 550	1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? • Resident #32 will be served and [NJ Exec] in a manner that promotes respect and dignity • Resident #42 will be served their meal in a manner that promotes respect and dignity 2. How will you identify other residents having the potential to be affected by the deficient practice and what corrective actions will be taken? • All residents in the dining room on Skilled 2 had the potential to be affected by the deficient practice • The nursing team was re-educated by the ADON on feeding residents in a	

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F 550	Continued From page 2 #32 while [NJ Exec Order 26] the resident tomato soup and sips of his/her beverage. At 12:47 PM, LPN #1 stopped [NJ Exec Order 26] Resident #32 as the resident had finished his/her soup. The LPN then walked away from the resident. At 12:55 PM, the Resident #32 was served an entree of pureed fettuccine and pureed broccoli. LPN #1 was now seated at a different table [NJ Exec Order 26] another resident. There were no staff [NJ Exec Order 26] Resident #32 his/her entree. At 1:03 PM, Certified Nursing Assistant (CNA) #1 walked over to Resident #32 and started to [NJ Exec O] the resident his/her entree while standing over the resident. The CNA then left to [NJ Exec O] another resident at a different table. Resident #32 was not finished eating the entree. At 1:12 PM, the CNA #2 walked over to Resident #32 and started to [NJ Exec O] the resident his/her entree while standing over the resident. The CNA then left the resident to [NJ Exec O] another resident seated at the same table. Resident #32 was not finished eating the entree. At 1:19 PM, LPN #2 walked over to Resident #32 and gave the resident sips of his/her beverage while standing over the resident. At that time, the resident was served a pureed dessert. The LPN [NJ Exec] the resident his/her dessert while standing over the resident. The resident [NJ Exec Order 26.4b1] of the dessert. LPN #2 never offered the resident the rest of his/her entree and staff assisted the resident out of the dining room. At 1:27 PM, the surveyor interviewed LPN #1 who stated there were usually five CNAs who each	F 550	manner that promotes respect and dignity • The dining team was re-educated by the Dining Director on a residents right to have a choice of all menu items 3. What measures will be put into place or what system changes will you make to ensure that the deficient practice does not recur? • All residents, regardless of cognition, perceived preferences and/or past behaviors, will be offered a choice of all menu items at all meals • If a resident requests a menu item, they will receive it, regardless of the staff assumption that they won't eat it • All residents requiring feeding assistance will be fed in a manner that promotes respect and dignity • Staff will sit next to residents they are providing feeding assistance to • Residents requiring feeding assistance with be seated together and a staff member will be assigned to each table that has residents needing feeding assistance • Residents will not have to wait long periods of time in between courses of the meal to be fed • The dining staff will serve an entire table of residents before serving another table • Residents will not be removed from the dining room without staff offering all courses to the resident • Prior to a resident being removed from the dining room, staff will confirm if they would like to finish their meal 4. How the corrective action will be monitored to ensure that the deficient	

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F 550	Continued From page 3 had a resident on their assignments who required assistance with [NJ Ex Order 26.4b] The LPN further stated that staff assisting residents with [NJ Ex Order 26.4b] should sit down in a chair side by side with the resident in order to monitor the resident during the meal. When asked about Resident #32, the LPN stated she [NJ Ex Order 26.4b] resident his/her soup and juice, but that she should have been seated next to the resident. The LPN further stated that residents should be [NJ Exec] within 10 minutes of their food being served. At 1:31 PM, the surveyor interviewed CNA #1 who stated staff should be eye level with the resident while assisting with [NJ Exec Order 26.4b] When asked about Resident #32, the CNA stated she should have been eye level with the resident when assisting with [NJ Exec Order 26.4b] The CNA further stated that residents should be fed within "a minute or so" to prevent the food from getting cold. At 1:35 PM, the surveyor interviewed CNA #2 who stated staff assisting residents with [NJ Exec Order 26.] should be sitting next to the resident. When asked about Resident #32, the CNA stated she could not sit next to the resident because there was not enough room, but that staff should be ensuring residents are positioned in a way that staff can be seated while [NJ Exec Order 26.4b] The CNA further stated that staff should [NJ Exec O] residents immediately when the food is served to prevent the food from getting cold. At 1:40 PM, the surveyor interviewed LPN #2 who stated staff assisting residents with [NJ Exec Order 26.] should "probably" be sitting next to the resident to maintain eye contact. When asked about Resident #32, the LPN stated she should have been seated while [NJ Exec Order 26] the resident. The LPN	F 550	practice does not recur (QA)? Who will be responsible? • The Healthcare Manager will perform audits in all dining rooms, three times per week, to ensure the dining team if offering and providing residents with menu item choices • The DON will perform audits in all dining rooms, three times per week, to ensure the nursing team is feeding residents in a manner that promotes respect and dignity – sitting next to the resident they are feeding and feeding the resident each course in timely manner • The Healthcare Manager will report the findings of the audits at the monthly QAPI meetings for a minimum of three months • The DON will report the findings of the audits at the monthly QAPI meetings • Based on compliance results, the QAPI committee will determine if the audits and reports need to continue past the three months	

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F 550	Continued From page 4	F 550		

further stated that staff should assist residents with [NJ Exec Order 26] "right away" while the food is hot.

The surveyor reviewed the medical record for Resident #32.

A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included, but were not limited to, [NJ Exec Order 26.4b1] [redacted]

A review of the quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [NJ Exec Order 26.4b1], included the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, which indicated the resident's [NJ Exec Order 26.4b1] was [NJ Exec Order 26.4b] [redacted] Further review of the MDS included the resident was [NJ Exec Order 26.4b1] on staff [NJ Exe] [redacted] eating.

On 2/11/25 at 1:08 PM, the surveyor interviewed the US FOIA (b)(6) [redacted], in the presence of the US FOIA (b)(6) [redacted] who stated staff should sit next to the resident while assisting with [NJ Exec Order 26.] to maintain eye contact and to conversate with the resident. The [US FOIA (b)] [redacted] further stated that resident should be fed immediately after the food is served so that the resident is not watching other residents eat, and so the food is warm and more pleasurable.

A review of the facility's "Assistance with Meals" policy, undated, included "Residents who cannot feed themselves will be fed with attention to safety, comfort, and dignity."

A review of the facility's "Food Presentation Policy," undated, included, "Timing and Freshness: Dishes should be prepared and

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F 550	Continued From page 5 served immediately after plating to maintain the freshness of the food and preserve its appearance." 2.) On 2/10/25 at 12:11 PM, the surveyor observed a menu posted outside of the Second Floor Skilled Nursing Unit Dining Room which featured tomato soup, grilled cheese, or fettuccine alfredo with broccoli and a soft cookie. Further review of the Menu indicated that lunch was scheduled from 12:00 PM to 1:00 PM. At 12:22 PM, a rolling cart was brought into the dining room with three meal trays on it which were passed out to the residents. Meal choices were given to the residents prior to meal service and alternatives were offered. At 12:30 PM, the surveyor observed Resident #42 seated in a wheel chair at the dining room table awaiting meal delivery. The resident's meal ticket was on the table and indicated that the resident was ordered a [redacted] The resident called out, [redacted] At 12:32 PM, Dietary Service Aide (DSA) #2 reviewed Resident #42's meal ticket and took the resident's meal order. The resident [redacted] fettuccini alfredo with broccoli and instead requested a peanut butter and jelly sandwich. DSA #2 then offered Resident #42 mashed potatoes and broccoli and the resident stated yes to both. Resident #42 informed DSA #2 that he/she was, "[redacted]." At 12:43 PM, Certified Nursing Assistant (CNA) #3 was observed [redacted] tomato soup to an unsampled resident who was seated at the same	F 550		

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F 550	Continued From page 6 table as Resident #42 . CNA #3 then proceeded to request soup for both Resident #42 and a second unsampled resident who was seated at the same table. At 12:45 PM, the second unsampled resident was served tomato soup while Resident #42 watched the two residents seated at the table eating their soup. Resident #42 had only been served a cold beverage at that point and stated, '[redacted] At 12:47 PM, Resident #42 was served a peanut butter and jelly sandwich that was cut into four small pieces with the crust removed and had not received the mashed potatoes and broccoli that were ordered. The resident then proceeded to eat the sandwich [redacted] At 12:56 PM, the CNA #3 requested food for the table and DSA #2 stated, "I have to serve the food table by table." At that time, Resident #42 stated, [redacted]." Resident #42 then requested chicken noodle soup. CNA #3 stated that the facility only had tomato soup, to which Resident #42 did not respond. At 1:13 PM, the two unsampled resident's at Resident #42's table were served dessert. Resident #42 had finished his/her peanut butter and jelly sandwich and was not offered any dessert. At 1:17 PM, a Certified Nursing Assistant (CNA) asked Resident #42 if he/she were finished with their meal and failed to offer the resident dessert before they proceeded to remove the resident from the dining room.	F 550		

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F 550	Continued From page 7 At 1:18 PM, the surveyor interviewed DSA #2 and asked her why Resident #42 had not received their mashed potatoes, broccoli, soup and dessert and she stated that there had been a mishap due to the staff not communicating. DSA #2 further stated that the resident [NJ Exec Order 26.4b1] soup and would have wasted it if it were served. At 1:21 PM, the surveyor interviewed CNA #3 who stated that Resident #42 would not have eaten mashed potatoes and broccoli if they had brought it. CNA #3 stated that the resident only wanted chicken noodle soup, not tomato. CNA #3 stated that the resident liked to eat cake and would have eaten dessert if it would have been served. On 2/11/25 at 2:25 PM, the surveyor interviewed the [US FOIA (b)(6)] who stated that everyone should have been served at the same time for dignity. The [US FOIA (b)] stated that everyone should have been offered everything on the menu and should have been given a choice of every appetizer, entree and dessert on the menu. The [US FOIA (b)] further stated, "The resident should be given a choice every single time". A review of the facility's undated "Dignity" policy included: "Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem." A review of the facility's undated "Assistance with Meals" policy included: "Residents shall receive assistance with meals in a manner that meets the individual needs of each resident." NJAC 8:39-4.1(a) 12	F 550		

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F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Complaint #NJ179408 Based on interview, record review, and review of facility documents, it was determined that the facility failed to report an allegation of [redacted] to the New Jersey Department of Health and the Office of the Ombudsman for the	F 609	1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? " Resident #197 was in the community for [redacted] and has been discharged	3/28/25

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F 609	Continued From page 9 Institutionalized Elderly in a timely manner in accordance with state and federal requirements. This deficient practice was identified for 1 of 1 Nurse (Licensed Practical Nurse (LPN) #4 and 3 of 3 residents (Resident #197, #198, and #199) reviewed for [redacted] medication administration on 1 of 4 nursing units (Rehabilitation Unit #1) and was evidenced by the following: Refer to F755 On 2/11/25 at 8:48 AM, the surveyor reviewed the medical record of Resident #197. A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included, NJ Exec Order 26.4b1 [redacted] A review of the resident's most recent comprehensive Minimum Data Set (MDS), an assessment tool, dated [redacted], included the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, which indicated the resident's [redacted] was NJ Exec Order 26.4b1. Further review of the MDS revealed the resident had NJ Exec Order 26.4b1 that was described as [redacted] that occasionally [redacted] with [redacted] activities and day to day activities and that had [redacted] or had [redacted] the resident's [redacted]. A review of the individual comprehensive care plan (ICCP) included a focus area, dated [redacted] that the resident had NJ Exec Order 26.4b1 related	F 609	" Resident #198 was in the community for NJ Exec Order 26.4b1 and has been discharged " Resident # 199 was in the community for NJ Exec Order 26.4b1 and has been discharged 2. How will you identify other residents having the potential to be affected by the deficient practice and what corrective actions will be taken? " All residents who are prescribed narcotic medications had the potential to be affected by the deficient practice • The DON/ADON conducted a review of all residents who were receiving narcotics when the deficient practice occurred, They conducted a review of their narcotic inventory log, checked against their MAR, to determine if there were any discrepancies 3. What measures will be put into place or what system changes will you make to ensure that the deficient practice does not recur? " The NHA or DON will report any and all instances of alleged violations to the New Jersey Department of Health and the Ombudsman Office within a timely manner in accordance with the regulations " A suspicion of an alleged violation will trigger the reporting, not once the suspicion is verified " The NHA has reviewed the rules of timely reporting alleged violations " The NHA will educate the DON/ADON on the rules of timely reporting alleged violations. The education will be completed by March 13, 2025	

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F 609	Continued From page 10 to (r/t) NJ Exec Order 26.4b1. Interventions included: Be [redacted] to NJ Exec Order 26.4b1 signs and symptoms (s/s) of [redacted] Notify Nurse as needed if resident complains of (c/o) or shows s/s of [redacted] A review of the Order Summary Report (OSR) included the following physician's orders (PO): -A PO, dated [redacted], for NJ Exec Order 26.4b1 [redacted] give one (1) tablet every six (6) hours as needed for NJ Exec Order 26.4b1 for 14 days [redacted] management. -A PO, dated [redacted], for NJ Exec Order 26.4b1 [redacted] give one (1) tablet by mouth every four (4) hours as needed for NJ Exec Order 26.4b1 related to displaced NJ Exec Order 26.4b1 of [redacted], subsequent encounter for [redacted] with NJ Exec Order 26.4b1 for 14 days. On 2/11/25 at 8:48 AM, the surveyor reviewed the medical record of Resident #198. A review of the Admission Record revealed the resident had diagnoses which included, [redacted] A review of the most recent comprehensive MDS, dated [redacted], included the resident had a BIMS score of [redacted] out of 15, which indicated the resident's [redacted] was [redacted]. Further review of the MDS revealed the resident had not NJ Exec Order 26.4b1 or [redacted] at any time in the past five days during a [redacted] assessment interview. A review of the ICCP included a focus area, dated	F 609	" The DON/ADON will educate the nursing supervisors on reporting any suspicious or inappropriate activity immediately. The education will be completed by March 27, 2025 4. How the corrective action will be monitored to ensure that the deficient practice does not recur (QA)? Who will be responsible? " The NHA or DON will be responsible for ensuring that any and all instances of alleged violations are reported to the New Jersey Department of Health and the Ombudsman Office in accordance with the regulations " All alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury • Any violations that require being reported to the New Jersey Department of Health and the Ombudsman will be audited for compliance of reporting timely within the regulation guidelines • The NHA or DON will audit all reportable events monthly for compliance for a minimum of three months • The NHA will report at the monthly QAPI meetings for a minimum of three months that reportable events were reported in a timely manner within the regulation guidelines	

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	315499	A. BUILDING _____ B. WING _____	C 02/13/2025

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LIONS GATE	1100 LAUREL OAK ROAD VOORHEES, NJ 08043

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F 609	Continued From page 11 NJ Exec Order 26.4, that the resident had a t NJ Exec Order 26.4b1 [redacted]. Interventions included: Observed for NJ Exec Order 26.4b1 [redacted]. Notify nurse as needed. A review of the OSR included the following PO: -A PO, dated NJ Exec Order 26.4, for NJ Exec Order 26.4b1 [redacted] give 1 tablet by mouth every 4 hours as needed for NJ Exec Order 26.4b1 [redacted] 14 days. -A PO, dated NJ Exec Order 26.4, for NJ Exec Order 26.4b1 [redacted] give two (2) tablets by mouth every 4 hours as needed for NJ Exec Order 26.4b1 [redacted] On 2/11/25 at 8:48 AM, the surveyor reviewed the medical record of Resident #199. A review of the Admission Record revealed the resident had diagnoses which included, NJ Exec Order 26.4b [redacted] A review of the most recent comprehensive Minimum Data Set (MDS) dated NJ Exec Order 26. [redacted] included the resident had a BIMS score of NJ Ex [redacted] out of 15, which indicated the resident's NJ Exec Order 26.4b1 [redacted] was NJ Exec O [redacted] Further review of the MDS revealed the resident had NJ Exec Order 26.4b1 [redacted] that was described as NJ Exec Order 26.4b1 [redacted] that had NJ Exec Orde [redacted] or had NJ Exec Order 26.4b1 [redacted] the resident's NJ Exec Order 26.4 [redacted] activities, day to day activities or the resident's NJ Exec Order 26.4b1 [redacted]. A review of the ICCP included a focus area, dated NJ Exec Order 26.4b [redacted] that the resident had a risk of NJ Exec O [redacted] related to NJ Exec Order 26.4b1 [redacted] and NJ Exec Orde [redacted] Interventions	F 609	• Based on compliance results, the QAPI committee will determine if the audits and reports will continue past the three months	

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included: Administer meds as ordered. Monitor effectiveness and for any adverse side effects and Assess need for [redacted] meds prior to activities of daily living (ADLs)/and or therapy.

A review of the OSR included the following PO:
-A PO, dated [redacted] NJ Exec Order 26.4b1 [redacted] Give 1 tablet by mouth every 4 hours as needed for NJ Exec Order 26.4b1 for 14 days.
-A PO, dated [redacted] for NJ Exec Order 26.4b1 [redacted] Give 2 tablets by mouth every 4 hours as needed for [redacted] for 14 days.

On 2/11/25 at 12:01 PM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM #1) who stated the oncoming nurse, and the outgoing nurse should both count the [redacted] and sign the book to ensure that the [redacted] count was right, and the medications had not been compromised. LPN/UM #1 further stated that there was a recent problem with an agency nurse who signed out [redacted] but it was questionable whether the residents had received them. LPN/UM #1 stated that the incident was reported and was investigated by the US FOIA (b)(6) [redacted].

On 2/11/25 at 1:36 PM, the surveyor requested and received a copy of a Long-Term Care Reportable Event Survey that was reported to the New Jersey Department of Health on 10/4/24, for an event that occurred on [redacted] at 7:00 PM, six (6) days after the event, and detailed that there was a [redacted] or [redacted] of [redacted] on the [redacted] Nursing Unit.

A review of a narrative report detailed that on [redacted] it was noted that three (3) residents had [redacted] removed and signed off from their

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narcotic inventory record, and none of the doses were signed off on their medication administration record (MAR). Two of the residents denied being medicated for [NJ Exec C] and stated they were not medicated for [NJ Exec C] by the nurse on this day. It was also noted that on [NJ Exec Order 26.4b], three doses of medication were removed from the inventory, however, were not signed off as administered and the resident stated that he/she has not taken anything for [NJ Exec C] since [NJ Exec Order 26.4]. It was suspected that the same nurse removed these doses from inventory and changed the date and [NJ Exec Order 2] someone else's signature. The nurse was placed on the do not return list and it was reported to her agency.

Further review of the Long-Term Care Reportable Event Survey revealed the Office of the Ombudsman for the Institutionalized Elderly was notified of the event on 10/4/24 at 4:45 PM, six days after the event occurred.

Further review of the investigation included a Report of Theft or Loss of Controlled Substances (Drug Enforcement Agency (DEA) Form 106) which detailed that there were fourteen [NJ Exec Order 26.4b1] tablets reported stolen and one [NJ Exec Order 26.4b1] tablet was reported stolen.

On 2/11/25 at 2:06 PM, the surveyor interviewed the [US FOIA (b)] who stated that LPN #5 and LPN #6 reported [NJ Exec Order 26.4b1] from LPN #4 ([US FOIA (b)(6)]) which included [NJ Exec Order 26.4b1] to the supervisor. The [US FOIA (b)] stated that LPN #4, was observed down the hall passing medication past the shift change and had the [NJ Exec Order 26.4b] inventory book opened, as she looked in the computer for a long time. The [US FOIA (b)] stated that the [NJ Exec Order 26.4b]

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inventory was accurate when LPN #6 and LPN #4 counted at 7 PM. The [redacted] stated that LPN #5 noted that [redacted] medications were signed out on the time that she worked that were not her signature and she stated the [redacted] signature raised a suspicion. The [redacted] stated that the first instance was obvious for Resident #199, because the resident denied receipt of the medication and a review of the MAR did not reflect receipt. The [redacted] stated that the resident stated that their last dose was on [redacted]

At that time, the [redacted] reviewed Resident #199's NJ Exec Order 26.4b1 [redacted] tablets which indicated that on [redacted] at 7 AM, on [redacted] at 11:30 AM, and on [redacted] at 4:00 PM, two tablets were signed out by someone other than LPN #5 who was assigned to the resident on this date, and the signature did not belong to LPN #5, or anyone who worked on that date. The [redacted] further stated that LPN #4 was assigned to Resident #199 on [redacted] and signed out two tablets of NJ Exec Order 26.4b1 to the resident at both 12:20 PM and at 6:12 PM, for a total of ten tablets.

At that time, the [redacted] stated that Resident #197 was unable to tell us if he/she was medicated for [redacted] or not, but two tablets of [redacted] and one [redacted] tablet were signed out on the [redacted] and were not signed out on the MAR and there was an established pattern.

At that time, the [redacted] reviewed Resident #198's [redacted] with the surveyor which indicated that on [redacted] at 9:30 AM and 6:40 PM, LPN #4 signed out two NJ Exec Order 26.4b1 [redacted] tablets which had not been signed out on the MAR.

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F 609	Continued From page 15 On 2/12/25 at 2:26 PM, in the presence of the [redacted] and survey team, the [redacted] stated that she did not know when she was required to notify the NJDOH and the Office of the Ombudsman for the Institutionalized Elderly of a suspected and alleged [redacted]. The [redacted] stated that it was not reported right away because of a delayed response on behalf LPN #4. The [redacted] stated that she was unable to immediately confirm [redacted] and wanted to interview LPN #4 because she was not sure if it were actual [redacted] and did not want to create a false report. The [redacted] stated that she was not sure of what the required reporting timeframe was for notifying both the NJDOH and the Office of the Ombudsman for the Institutionalized Elderly of an [redacted] The [redacted] further stated that the day that she reported, was the day she decided that she was going to treat it as [redacted] when LPN #4 failed to comply with a face-to-face interview. The [redacted] further stated that she had not provided a summary and conclusion to the NJDOH yet because they had not requested it. A review of the facility's undated "Reportable Event Policy" included: Mandatory reporting of incidents that can affect the health, safety, or well-being of residents is required. ...Reporting Procedure: ...External Reporting: The Director of Nursing or Healthcare Administrator will determine the appropriate bodies that need to be informed such as the NJDOH, Ombudsman, Policy, Physician, local health department, and family. A review of the facility's undated "Drug Diversion	F 609		

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F 609	Continued From page 16 and Prevention Policy" included: ...Reports of confirmed drug diversion will be submitted to the NJDOH, law enforcement, and licensing boards as required ... NJAC 8:39-9.4(f)	F 609		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and	F 656		3/28/25

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F 656	Continued From page 17 desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and review of pertinent facility records, the facility failed to develop and implement an individualized comprehensive care plan for a resident that was requiring an NJ Exec Order 26.4b1 medication. This deficient practice was identified for 1 of 5 residents (Resident #29) reviewed for medication regimen. On 2/10/25 at 10:00 AM, during the initial tour, the surveyor observed Resident #29 NJ Exec Order 26 and NJ Exec Ord fully dressed, sitting in a wheelchar in their room. The survyeor reviewed the medical record for Resident #29. A review of the Admission Record, an admission summary, revealed that the resident had the diagnosis which included, NJ Exec Order 26.4b1	F 656	1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? " For Resident # 29, the following was completed: " A review of the attending physician□s progress note, and a review of the NJ Exec Order consultant's progress note to identify and confirm diagnosis of specified NJ Exec Order or NJ Exec Order 26.4b1 " A check of the current physician order sheet for the presence of corresponding NJ Exec Order 26.4b1 medication " An individualized comprehensive care plan for NJ Exec Order 26.4b1 medication was implemented 2. How will you identify other residents having the potential to be affected by the deficient practice and what corrective actions will be taken? " All residents had the potential to be	

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F 656	Continued From page 18 NJ Exec Order 26.4b1 [redacted] A review of the resident's most recent quarterly Minimum Data Set (MDS), an assessment, dated NJ Exec Order 26.4b1 included the resident had a Brief Interview for Mental Status (BIMS) score of NJ Exec out of 15 which indicated the resident's NJ Exec Order 26.4b1 was NJ Exec Order Further reveiew in Section NJ E of the MDS indicated that the resident was receiving NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 medication. A review of the active Order Summary Report (OSR) for NJ Exec Order 26.4b1, included the following physician orders: A PO, dated NJ Exec Order 26.4b1, for NJ Exec Order 26.4b1 [redacted], give 1 tablet by mouth as needed for NJ Exec Orde [redacted] related to NJ Exec Order 26.4b1 A PO, dated NJ Exec Order 26.4b1, for NJ Exec Order 26.4b1 by mouth. A review of the NJ Exec Order 26.4b1 Medication Administration Record (MAR) revealed that Resident #29 was receiving NJ Exec Order 26.4b1 [redacted] by mouth daily and NJ Exec Order 26.4b1 by mouth at bedtime.	F 656	affected by the deficient practice " The MDS staff will complete a chart audit of all residents to determine if any residents are receiving psychotropic medication and don□t have an individualized comprehensive care plan " If a resident is identified as receiving psychotropic medication and doesn□t have an individualized comprehensive care plan, one will be initiated 3. What measures will be put into place or what system changes will you make to ensure that the deficient practice does not recur? • The DON began in-servicing the MDS and nursing staff on February 12, 2025, education will be completed by March 27, 2025 " MDS staff will run an orders audit weekly to identify any new orders for psychotropic medication and an individualized comprehensive care plan will be implemented if not currently in place " The MDS staff will check each unit□s 24-hour report for behavior charting and/or new medication orders for psychotropic medication and implement an individualized comprehensive care plan if not currently in place 4. How the corrective action will be monitored to ensure that the deficient practice does not recur (QA)? Who will be responsible? " The MDS staff will perform monthly audits on all residents to confirm they have an appropriate individualized comprehensive care plan, the audits will be conducted for a minimum of three	

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F 656	Continued From page 19 A review of individualized comprehensive care plan (ICCP) did not include a care plan including interventions for an NJ Exec Order 26.4b1 or NJ Exec Order 26.4b1 medication. On 2/10/25 at 11:00 AM, the surveyor requested from the US FOIA (b)(6)) a copy of Resident #29's ICCP. Futher review of the ICCP, included a focus area for the use of NJ Exec Order and NJ Exec Order 2 initiated on NJ Exec Order 26.4 after surveyor inquiry. On 2/11/25 at 10:40 AM, the surveyor conducted an interview with the Registered Nurse (RN #3) who stated that when a resident had any NJ Ex Order 26.4b issues the US FOIA (b)(6) should initiate a care plan immediately. She then stated that she could initiate the care plan as well. On 2/11/25 at 10:56 AM, the surveyor interviewed the Licensed Practical Nurse (LPN #8) who stated that a resident with NJ Exec Order 26.4b1 or NJ Ex Order 26.4b1 should be care planned. She then stated that she would have to look at the policy. On 2/12/25 at 1:23 PM, the surveyor interviewed the US FOIA (b) who stated that when she was making copies of the care plans for surveyor, she noted the NJ Exec Order 26.4b1 medications were not on the care plan. The US FOIA (b) then stated that she could not provide copies of the ICCP without updating the care plan. The US FOIA (b) stated that the care plan should have been initiated within a short period of time. and that the US FOIA (b)(6) or anyone could have initiated the care plan. A review of facility's "Behavioral Management" policy dated May 2024, included, that all residents receive care and services to assist him or her to	F 656	months " The MDS staff will report their audit findings at the monthly QAPI meeting for a minimum of three months " Based on compliance results, the QAPI committee will determine if the audits and QAPI reports need to continue past three months	

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F 656	Continued From page 20 reach their highest level of mental and psychosocial functioning through interdisciplinary evaluation and assessments. Procedure Guidelines 7. the RAI [Resident Assessment Instrument] care plan process resident behavior management plan, interventions and effectiveness will be reviewed.	F 656		
F 692 SS=D	NJAC 8:39-11.1 Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review,	F 692	1. What corrective actions will be	3/28/25

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F 692	Continued From page 21 and review of pertinent facility documents, it was determined that the facility failed to obtain a [NJ Exec Order 26.4b1] according to the facility's policy for a resident with a history of NJ Exec Order 26.4b1 This deficient practice was identified for 1 of 1 resident (Resident #51) reviewed for [NJ Exec Order 26.4b1] and evidenced by the following: On 2/10/25 at 1:01 PM, the surveyor observed Resident #51 in the first-floor skilled nursing unit dining room being served breakfast. The resident received pancakes cut into bite sized portions. The resident complained that the pancakes were cold and did not eat the pancakes. On 2/11/25 at 8:20 AM, the surveyor observed Resident #51 in the first-floor skilled nursing unit dining room being served breakfast. The resident received pancakes cut into bite sized portions. The resident ate about 50% of their meal. The surveyor reviewed the medical record for Resident #51. A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included, NJ Exec Order 26.4b1 [redacted] A review of the quarterly Minimum Data Set (MDS), an assessment tool, dated [NJ Exec Order 26.4b], included the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, which indicated the resident's [NJ Exec Order 26.4b1] was [NJ Exec Order 26.4b1] [redacted] Further review of the MDS revealed the resident had a NJ Exec Order 26.4b1 or [NJ Exec Order 26.4b1] in the [NJ Exec Order 26.4b1], or [NJ Exec Order 26.4b1] in the last [NJ Exec Order 26.4b1]	F 692	accomplished for those residents found to have been affected by the deficient practice? " Resident # 51 was [NJ Exec Order 26.4b1] on NJ Exec Order 26.4b1 for accuracy " The Dietician, Physician and POA were notified of the [NJ Exec Order 26.4b1] as evidenced by nursing documentation, and Dietician and Physician follow up 2. How will you identify other residents having the potential to be affected by the deficient practice and what corrective actions will be taken? " All residents have the potential to be affected by the deficient practice " The DON completed an audit on all residents to identify any potential weight discrepancies " Any resident identified with a weight discrepancy was reweighed for confirmation " For any resident identified with undesirable weight gain or loss, the Dietician, Physician and POA were notified, as evidenced by nursing documentation 3. What measures will be put into place or what system changes will you make to ensure that the deficient practice does not recur? " The ADON began in-servicing the nursing team on the facility weight policy on February 12, 2025. The education will be completed by March 27, 2025 " Any discrepancy in a resident weight, will trigger a re-weigh of the resident, no later than the following day " The Unit Manager will audit resident monthly weights for compliance with the	

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F 692	Continued From page 22 NJ Exec Order 26.4b while not on a physician-prescribed NJ Exec Order 26.4b1. A review of the individual comprehensive care plan (ICCP) included a focus area, dated NJ Exec Order 26.4, that the resident had NJ Exec Order 26.4b1 problem related to NJ Exec Order 26.4b1 . Interventions included: NJ Exec Order 26.4, monitor weight as ordered. Notify US FOIA (b)(6) as needed of weight gain/loss. A review of the Order Summary Report (OSR), dated as of NJ Exec Order 26.4b, included the following physicians' orders: A PO, dated NJ Exec Order 26.4b, for NJ Exec Order 26.4b1 . A PO, dated NJ Exec Order 26.4b, for a NJ Exec Order 26.4b1 two times a day for NJ Exec Order 26.4b1. A PO, dated, NJ Exec Order 26, for NJ Exec Order 26.4b1 times 4 weeks one time a day every Wednesday for 4 weeks. A review of the US FOIA (b)(6) dated NJ Exec Order 26.4, included the resident had a NJ Exec Order 26.4b1 in the past few NJ Exec Order 26.4b NJ Exec Order 2 remains good, NJ Exec Order 26.4b1 . Further review of the US FOIA included recommendations to NJ Exec Order 26.4b1, NJ Exec Order 2 trends and NJ Exec Order 26.4b1 the NJ Exec Order 26.4b1 to twice a day. A review of the NJ Exec Order 26.4b and Vitals Summary, as of NJ Exec Order 26 included the following NJ Exec Order 26.4b On NJ Exec Order 26.4, the resident NJ Exec Order 26.4b NJ Exec Order 26 . (wheelchair)	F 692	facility weight policy • The ADON will in-service the Registered Dietician by March 27, 2025 on the facility weight policy " The Dietician will review weights, if a weight discrepancy exists and there isn□t a re-wight, the Dietician will place an order for a re-weight " The Dietician will review and address any undesirable resident weight gains or losses by the 10th of each month 4. How the corrective action will be monitored to ensure that the deficient practice does not recur (QA)? Who will be responsible? " The ADON will audit 20% of resident charts monthly for a minimum of three months to identify: " Any weight discrepancies " If any weight discrepancies occurred, that a re-weigh was completed " The Dietician, Physician and POA were notified as evidenced by nursing documentation " The ADON will report the audit findings to the to the QAPI committee monthly for a minimum of three months " Based on compliance results, the QAPI committee will determine if the audits and QAPI reports need to continue past the three months	

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F 692	Continued From page 23 On [redacted], the resident [redacted]. (wheelchair)- with incorrect documentation added by [redacted] On [redacted], the resident [redacted]. (wheelchair)- with incorrect documentation added by the [redacted] On [redacted], the resident [redacted]. (wheelchair) On [redacted] the resident [redacted]. (wheelchair) On [redacted], the resident [redacted]. (sitting) On [redacted], the resident [redacted]. (standing) A PO, dated [redacted], included an order to [redacted] one time. A review of the [redacted] Medication Administration Record (MAR) revealed that a [redacted]. was documented in the MAR on [redacted] at 3:28 PM. A review of the Progress Notes (PN), dated [redacted], did not include evidence that a [redacted] was attempted after the documented [redacted] of more than [redacted] or that the [redacted] or physician was notified of the [redacted] and [redacted]. On 2/11/25 at 9:52 AM, the surveyor interviewed the Certified Nursing Assistant (CNA #4) who stated the nurse scheduled the [redacted] that the CNAs needed to obtain weekly. The CNA further stated that she reports the [redacted] to the nurse but does not look at the resident's [redacted] history for comparison. CNA #4 explained that if a resident needed to be [redacted], the nurse	F 692		

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F 692	Continued From page 24 would instruct the CNA to obtain the [NJ Exec Order 2] at that time. CNA #4 stated that the nurse would put the [NJ Exec Order 26.] in the electronic medical record (EMR). On 2/11/25 at 9:56 AM, the surveyor interviewed the Licensed Practical Nurse (LPN #3) who she was the nurse for Resident #51 that day. LPN #3 stated that the nurse would put the residents who needed [NJ Exec Order 26.] on the daily schedule, the CNA would obtain the [NJ Exec Order 26] and the nurse would enter the [NJ Exec Order 2] into the EMR. If there was a NJ Exec Order 26.4b1, the nurse should [NJ Exec Order 26.4b] the resident and if the [NJ Exec Order 2] was verified, then the nurse should contact the [US FOM] and the doctor. LPN #3 reviewed the documented weights with the surveyor and confirmed that the resident should have been [NJ Exec Order 26.4b1] and the [US FOM] and doctor should have been notified on NJ Exec Order 26.4b1. On 2/11/25 at 10:46 AM, the surveyor interviewed the [US FOM] who stated that the CNAs would obtain the [NJ Exec Order 26.4b] and the nurse would document the [NJ Exec Order 26.] in the EMR. The [US FOM] explained that if a resident had a [NJ Exec Order 2] change since the last [NJ Exec Order 26] a [NJ Exec Order 26.4b1] should be obtained immediately to confirm if the [NJ Exec Order 2] was accurate. The [US FOM] further stated that for NJ Exec Order 26.4b1 the nurse would notify the [US FOM] and the doctor. The [US FOM] stated she was unaware of the [NJ Exec Order 2] obtained on NJ Exec Order 26.4b1. The [US FOM] stated that on [NJ Exec Order 26.] she had [NJ Exec Order 26.4b1] the residents [NJ Exec Order 26.4b1] to 2 times a day and had placed the resident on [NJ Exec Order 26] and to monitor the resident's [NJ Exec Order 26] On 2/11/25 at 11:33 AM, LPN #3 stated that she and CNA#4 [NJ Exec Order 26.4b1] the resident in the wheelchair and the [NJ Exec Order 2] obtained was [NJ Exec Order 2]	F 692		

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F 692	Continued From page 25 NJ Exec The US FOIA and the doctor was made aware of the NJ Exec Order 26.4b1. A review of the NJ Exec Order 26.4b1), dated NJ Exec Order 26.4, the US FOIA questioned the accuracy of the above NJ Exec Order 26.4b. The note reflected that the NJ Exec Order 2 due to a NJ Exec Order 26.4b1 and limited acceptance of prior NJ Exec Order 26.4b1. The resident continued with NJ Exec Order 26.4b1, NJ Exec Order 26.4b1 of meals. The US FOIA will honor preferences to NJ Exec Order 26.4b1, will continue to NJ Exec Order 26.4b1, NJ Exec Order 2 trends and labs as available. On 2/12/25 at 12:15 PM, the surveyor interviewed the US FOIA (b)(6) who stated that when there was a discrepancy in Resident #51's NJ Exec Order 2 obtained on NJ Exec Order 26.4b1, the nurse should have NJ Exec Order 26.4b1 the resident to confirm the NJ Exec Order 26.4b1, then notified the US FOIA and the doctor. A review of the facility's "Weight Policy", undated, included that any weight change of 5% or more since the last weight assessment is retaken for confirmation. If the weight is verified, nursing will immediately notify the dietician.	F 692		
F 755 SS=E	NJAC 8:39 - 27.2 (a) Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of	F 755		3/28/25

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F 755	Continued From page 26 a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Complaint #NJ179408 Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to ensure a.) that the wound treatment cart was locked when not in use b.) accountability for the completion of the narcotic shift-to-shift count logs in accordance with the facility policy b.) an accurate account of the administration and documentation of controlled medications c.) properly dispose of medications at the time of resident refusal and d.) that expired medical supplies were not available	F 755	1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? a) Unlocked Treatment Cart " No residents were found to have been affected by the deficient practice b) Narcotic shift-to-shift count " No residents were found to have been affected by the deficient practice c) Accurate account of the administration and documentation of controlled medications	

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F 755	Continued From page 27 for use in resident care in the medication storage room and in the emergency crash cart. This deficient practice was identified during the medication storage task for 1 of 2 medication carts on 1 of 4 nursing units (Rehab 1 Nursing Unit), 1 of 2 medication rooms (Rehab 2 Nursing Unit Medication Room), and the Rehab 1 Nursing Unit Emergency Treatment Cart and was evidenced by the following: 1. On 2/11/25 at 10:36 AM, the surveyor, in the presence of Licensed Practical Nurse (LPN) #5, observed that the wound treatment cart was not locked. When interviewed, LPN #5 stated that she had just completed a wound treatment and had forgotten to lock the cart. LPN #5 stated that it was important to lock the Wound Treatment Cart when finished to ensure that no one accessed it. 2. On 2/11/25 at 10:37 AM, in the top drawer of the medication cart, the surveyor observed a Lidocaine Patch (a topical pain relief patch) that was previously opened and was dated 2/11. When interviewed, LPN #5 stated that the Lidocaine Patch was endorsed by the 11-7 nurse because the resident did not want it at the time it was last scheduled. LPN #5 was unable to state which resident the Lidocaine Patch was ordered for. 3. On 2/11/25 at 10:45 AM, the surveyor, in the presence of Licensed Practical Nurse (LPN) #5, reviewed the shift-to-shift "Controlled Drugs-Count Record" and the surveyor observed that on 2/10/25 at 7:00 PM, the Nurse on Signature (oncoming nurse) was blank and the Nurse Off Signature (outgoing nurse) was signed	F 755	" Resident #201 received their medication but LPN #5 failed to sign the medication out of the declining inventory log " LPN #5, assigned to Resident #201, signed out the medication when the surveyor identified it wasn□t signed out d) Properly dispose of medications at the time of resident refusal " No residents were found to have been affected by the deficient practice e) Expired Medical Supplies " No residents were found to have been affected by the deficient practice 2. How will you identify other residents having the potential to be affected by the deficient practice and what corrective actions will be taken? a) Unlocked Treatment Cart " All residents on Rehab 1 had the potential to be affected by the deficient practice " All medication and treatment carts were checked by the Unit Manager to ensure they were locked b) Narcotic shift-shift count " All residents who are prescribed narcotics had the potential to be affected by the deficient practice " The ADON and Unit Manager reviewed all narcotic books for shift-shift count logs for accuracy and completion c) Accurate account of the administration and documentation of controlled medications " All residents assigned to LPN #5 had the potential to be affected by the deficient practice " The declining inventory logs for the	

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F 755	Continued From page 28 by LPN #5. There was no further documentation on the form to indicate that the shift-to-shift narcotic count was performed on 2/11/25. LPN #5 stated that when she came in the outgoing nurse reviewed the Controlled Drug-Count Record and the oncoming nurse reviewed the narcotic count. LPN #5 stated that on 2/10/25, she was the oncoming nurse and LPN #6 was the outgoing nurse who had forgotten to sign. LPN #5 stated that today both she and LPN #6 had completed the shift-to-shift narcotic count, but they had both forgotten to sign. LPN #5 further stated that there were no reported discrepancies identified in the narcotic count. Further review of the Controlled Drugs-Count Record revealed that on 2/2/25, at 7:00 AM, the Nurse on Signature was blank, and a signature was noted in the space allotted for the Nurse Off Signature. On 2/4/25 at 7:00 AM, the Nurse on Signature was blank, and a signature was noted in the space allotted for the Nurse Off Signature. On 2/4/25 at 7:00 PM, a signature was noted in the space allotted for the Nurse on Signature and the Nurse Off was blank. LPN #5 stated that it looks like they forgot to sign. LPN #5 stated that both nurses should sign the Controlled Drugs-Count Record when they are finished counting. 4. At that time, in the presence of LPN #5, the surveyor reviewed the controlled substance logs for the Rehab 1 Nursing Unit medication cart and noted the following: Resident #201's prescription card (BINGO card, medication packaged in a blister package with cardboard backing) containing [redacted]) contained 20 tablets, but the declining inventory log indicated	F 755	residents assigned to LPN #5 were reviewed, and it was verified no other residents were found to have been affected by the deficient practice d) Properly dispose of medications at the time of resident refusal " All residents who refuse medications have the potential to be affected by the deficient practice " The ADON and Unit Manager checked all medication carts for any medications that were not discarded due to refusal e) Expired Medical Supplies " All residents had the potential to be affected by the deficient practice " An inspection of all medication storage rooms and emergency crash carts was performed by the Unit Manager and any expired items found were disposed of 3. What measures will be put into place or what system changes will you make to ensure that the deficient practice does not recur? a) Unlocked Treatment Cart " The Unit Manager/DON began in-servicing the nursing staff on the importance of locking medication treatment carts when unattended and the risks associated with unlocked carts. The in-service began February 12, 2025, and will be completed by March 27, 2025 " Signs will be placed on all carts to remind staff to lock them b) Narcotic shift-shift count " The DON in-serviced the Unit Manager on February 12, 2025 regarding the importance of checking the narcotic	

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F 755	Continued From page 29 that there were 21 tablets remaining. LPN #5 stated that she must have gotten distracted and had forgotten to sign it out. LPN #5 stated that it was important to sign the medication out on the declining inventory sheet at the time of administration to ensure that the NJ Exec Order 26.4b count was correct. LPN #5 stated that she did sign the medication out as administered on the resident's Medication Administration Record (MAR). Resident #201's prescription card containing NJ Exec Order 26.4b1 contained 23 capsules, but the declining inventory log indicated that there were 24 capsules remaining. LPN #5 stated that she must have gotten distracted and had also forgotten to sign the dosages out. On 2/11/25 at 12:01 PM, the surveyor interviewed Licensed Practical Nurse/Unit Manager (LPN/UM) #1 who stated that the oncoming nurse should count the NJ Exec Order 26.4b1 and the outgoing nurse should review the NJ Exec Order 26.4b1 Count Record Book to make sure that the NJ Exec Order 26.4b count is right, and the medications are not compromised. LPN/UM #1 stated that the nurses were required to sign the book when they come in and when they go out. LPN/UM #1 stated that the US FOIA (b)(6) came into the facility monthly and audited the NJ Exec Order 26.4b book. LPN/UM #1 stated that the NJ Exec Order 26.4b count has always been correct. LPN/UM # 1 stated that she would think that the nurses had not counted if they had not signed the NJ Exec Order 26.4b1-Count Record and NJ Exec Order 26.4b1 could be missing. At that time, LPN/UM #1 further stated that narcotics should be signed for when they were removed from the medication cart. LPN/UM #1	F 755	count book shift logs weekly for signature accuracy " The Unit Manager began in-servicing the nursing team on the importance of signing the narcotic count book shift logs per the facility policy. The in-service began on February 12, 2025 and will be completed on March 27, 2025 " The Unit Manager will check the narcotic count book shift logs weekly for signature accuracy " The pharmacy consultant will check the narcotic count book for signature accuracy during the monthly visit " A visual aid will be placed on all narcotic books to remind staff to sign off on the shift-shift narcotic count logs c) Accurate account of the administration and documentation of controlled medications " The Unit Manager began in-servicing the nursing staff on proper medication administration and documentation of narcotic medications The in-service began on February 12, 2025, and will be completed by March 27, 2025 " The Unit Manager will perform audits of narcotic medications three times a week, to ensure the declining logs match the narcotic inventory d) Properly dispose of medications at the time of resident refusal " The Unit Manager began in-servicing the nursing staff on proper medication disposal procedures, emphasizing refused medications. The in-service began February 12, 2025 and will be completed by March 27, 2025 " The Unit Manager will perform audits	

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F 755	Continued From page 30 stated that it was good practice because the narcotic count may be off if the nurse did not sign the book and only signed the Medication Administration Record (MAR). At that time, LPN/UM #1 further stated that the wound treatment cart should be locked at all times so that patients or families can not take anything out of it. On 2/11/25 at 1:52 PM, the surveyor interviewed the US FOIA (b)(6)) who stated that the nurses should count their NJ Exec Order 26.4b1 in the medication cart at the end of the shift for accuracy of NJ Exec Order 26.4b1 The US FOIA (b) further stated that the US FOIA (b)(6) was responsible to review the NJ Exec Order 26.4 book weekly for signatures being captured and to ensure accuracy of the documentation. At that time, the US FOIA (b) further stated that NJ Exec Order 26.4b medication should be signed out upon removing it from the medication cart in the book. The US FOIA (b) stated that it was not sufficient to just sign the medication out on the Medication Administration Record (MAR) because you are required to sign the medication out when it is removed. The US FOIA (b) stated that the mismanagement of NJ Exec Order 26.4b1 or missing dosages were a concern if NJ Exec Order 26.4b1 were not signed out from the cart at the time of removal. On 2/12/25 at 11:53 AM, the surveyor interviewed the US FOIA (b)(6) who stated that she was at the facility last week and reviewed three random medication carts for the NJ Exec Order 26.4b count. The US FOIA stated that she checked the signature logs at the back of the book and sometimes there was one missed signature here and there. The US FOIA stated that she had not	F 755	of medication carts three times a week, to ensure compliance of proper medication disposal e) Expired Medical Supplies " Medical supplies will be removed from medication storage rooms and crash carts prior to the expiration date " The Unit Manager began in-servicing the nursing staff on the importance of checking expiration dates on all medical supplies in the medication rooms and crash carts. The in-service began February 12, 2025, and will be completed by March 27, 2025 " The Unit Manager began in-servicing the nursing staff on the importance of discarding all medical supplies prior to the expiration date. The in-service began February 12, 2025, and will be completed by March 27, 2025 " The inspection log for the crash carts will be updated to include expiration dates of all medical supplies in the cart " Crash carts will be checked daily by the Nursing Supervisor for expired items " The medication rooms will be checked monthly by the Unit Manager for expired items 4. How the corrective action will be monitored to ensure that the deficient practice does not recur (QA)? Who will be responsible? a) Unlocked Treatment Cart " The Unit Manger will perform audits on all medication and treatment carts three times per week to ensure they□re locked when unattended " The Unit Manger will report the audit findings at the monthly QAPI meeting for	

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F 755	Continued From page 31 performed medication pass observations at the facility as it was not part of their contract, but will going forward, as it was just initiated after surveyor inquiry. On 2/12/25 at 11:30 AM, the [redacted] provided the surveyor with a Medication Pass Observation dated form dated [redacted], which revealed that LPN #5 had not received a medication pass observation on that date because the former [redacted] indicated that LPN #5 had finished passing medications early due to a low census, and instead received a medication pass in-service with LPN #5 and reviewed administration of all types of meds. The facility failed to provide the surveyor with documented evidence that LPN #5 had received a medication pass observation when requested. On 2/12/25 at 2:41 PM, the [redacted] stated that she was not aware that the [redacted] was not doing medication pass observations at the facility and that they needed to be requested. At that time, the [redacted] further stated that she was responsible to ensure that LPN/UM #1 completed the narcotic record review and had not informed the LPN/UM #1 that it was her responsibility to do so. The [redacted] further stated that she was not aware of the frequency that the [redacted] performed narcotic record review. 5.) On 2/11/2025 at 10:03 AM, during a tour of the Rehab 2 Nursing Unit Medication Room, in the presence of LPN/UM #1, the surveyor observed the following expired supplies in the second drawer adjacent to the sink: culture swabs with an	F 755	a minimum of three months " Based upon compliance results, the QAPI committee will determine if the audits and reports need to continue past three months b) Narcotic shift-shift count " The Unit Manager will check the narcotic count book shift logs three times per week to ensure the in-coming and out-going nurses are signing the book " The Unit Manger will report the audit findings at the monthly QAPI meeting for a minimum of three months " Based upon compliance results, the QAPI committee will determine if the audits and reports need to continue past three months c) Accurate account of the administration and documentation of controlled medications " The Unit Manager will audit the narcotic medications three times per week to ensure the declining logs match the narcotic inventory " The Unit Manger will report the audit findings at the monthly QAPI meeting for a minimum of three months " Based upon compliance results, the QAPI committee will determine if the audits and reports need to continue past three months d) Properly dispose of medications at time of refusal " The Unit Manager will audit the medication carts three times per week to ensure compliance with proper medication disposal procedures " The Unit Manger will report the audit findings at the monthly QAPI meeting for	

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F 755	Continued From page 32 expiration date of 5/6/2024; and greater than 25, disposable sampling swabs with an expiration date of 11/24/2022. On 2/11/2025 at 10:23 AM, during a tour of the Rehab 1 Nursing Unit in the presence of LPN/UM #1, the surveyor observed the following expired items in the emergency crash cart: three suction connection tubing with an expiration date of 2/5/2024; one [redacted] swab with an expiration date of 12/22; one dial-a-flow tubing (a medical device used to control the flow of fluid via an intravenous line) dated 7/9/2024; one box of size medium disposable examination gloves with an expiration date of 2/2024; one box of size large nitrile disposable examination gloves with an expiration date of 12/2023. On 2/11/2025 at 10:28 AM, the surveyor interviewed LPN/UM #1 who stated that supplies should be within date to ensure proper function. LPN/UM #1 also stated that the night shift 11:00 PM to 7:00 AM nurse was responsible to the check the crash carts and that a staff member from Central Supply checked the carts monthly for expired items. On 2/11/2025 at 12:15 PM, during tour of the first floor common area, inside of an emergency crash cart the following expired items were observed: two boxes of disposable examination gloves with an expiration date of 2/2024. A review of the facility's undated "Administering Medications" policy included: Medications should be administered in a safe and timely, manner,	F 755	a minimum of three months " Based upon compliance results, the QAPI committee will determine if the audits and reports need to continue past three months e) Expired Medical Supplies " The Unit Manager will audit medication rooms and crash carts three times per week to ensure they don□t contain any expired items " The Unit Manger will report the audit findings at the monthly QAPI meeting for a minimum of three months " Based upon compliance results, the QAPI committee will determine if the audits and reports need to continue past three months	

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F 755	Continued From page 33 and as prescribed. ...The Director of Nursing Services will supervise and direct all nursing personnel who administer medications and/or have related functions ... ...During administration of medications, the medication cart will be kept closed and locked when out of sight of the medication nurse or aide ... A review of the facility's undated "Narcotic Count Policy" included: Purpose: To establish guidelines for the accurate and secure shift-to-shift counting of narcotics. ...The facility (name redacted) shall ensure the secure and accurate counting of narcotics at each shift change to prevent discrepancies and ensure resident safety ... Narcotic Count at Shift Change: At the beginning and end of each shift, the oncoming and outgoing licensed nurses shall conduct a joint count of all controlled substances. Both nurses shall verify the count against the narcotic record. Documenting and Record-Keeping: ...All narcotic administration shall be documented in the resident's medication administration record ... A review of the facility's undated "Receipt, Usage, Disposition, and Reconciliation of Controlled Medications Policy" included: ...Each administration must be recorded in the Medication Administration Record (MAR) and the narcotic record. ...A shift-to-shift controlled medication count shall be conducted and documented by outgoing and incoming licensed nurses. Monthly audits shall be performed to ensure compliance and identify any discrepancies. Any discrepancies must be reported immediately to the Nurse Manager or Nursing Supervisor and	F 755		

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F 755	Continued From page 34 DON or Facility Administrator ... A review of the facility's undated "Crash Cart Policy" policy included, "5. Routine Inspections: To ensure readiness ...Weekly Checks: Review expiration dates and replace as necessary." A review of the facility's undated "Emergency Cart Inspection and Inventory" policy included, "Procedures 2. Routine Inspections...Any missing, damaged, or expired items shall be replaced immediately."	F 755		
F 804 SS=E	NJAC 8:39-29.7 (c); 29.2(d) Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to ensure food served to residents was palatable. This deficient practice was identified for 5 out of 5 residents (Resident # 29, #31, #37, #74 and #75) who attended the Resident Council meeting conducted by the survey team on 2/10/25 and confirmed during the lunchtime meal service on	F 804	1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? " The Executive Chef will meet with Resident # 29 " The Executive Chef will meet with Resident # 31 " The Executive Chef will meet with Resident # 37	3/28/25

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F 804	Continued From page 35 2/11/25 for 1 of 4 nursing units (Skilled 1) tested for food palatability. This deficient practice was evidenced by the following: On 2/7/25 at 10:00 AM, during the initial tour of the Skilled 1 nursing unit, Resident #29 stated that the food "[redacted]" and the meat was tough. At 10:13 AM, Resident #37 stated that the food was cold, and the meat was tough and inedible. At 10:34 AM, Resident # 31 stated that the food was inedible, cold, and the meat was tough. On 2/10/25 at 10:37 AM, the surveyor conducted a resident council meeting with five [redacted] and [redacted] residents (Resident # 29, #31, #37, #74 and #75). All five residents stated the food was not good and the meat was tough. All five residents further stated that they had previously complained about the food at the monthly resident council meetings, but nothing had improved. Resident #29 stated that the chicken is served in a hard lump and cannot cut the chicken. Resident #75 added that the "food stinks." On 2/11/25 at 12:00 PM, the [redacted] provided the survey team with two meal trays from the Skilled 1 nursing unit satellite kitchen - a regular consistency tray and a pureed consistency tray. Three surveyors tasted the food and observed the following: Regular Sloppy Joe - no concerns with palatability Regular Cauliflower - tasted bland and mushy	F 804	" The Executive Chef will meet with Resident # 74 " The Executive Chef will meet with Resident # 75 • The Executive Chef will meet with all the above residents on March 18, 2025 after the dining committee meeting 2. How will you identify other residents having the potential to be affected by the deficient practice and what corrective actions will be taken? " All residents had the potential to be affected by the deficient practice " The Executive Chef and Dining Director, will attend the monthly dining committee meeting 3. What measures will be put into place or what system changes will you make to ensure that the deficient practice does not recur? " The Healthcare Manager will conduct weekly rounds in each dining room to receive resident feedback on meals " The Executive Chef and Assistant Director of Dining will review all current menu recipes, including altered consistency items " The Executive Chef will educate the kitchen production staff on recipe compliance by March 27, 2025 " A pre-meal tasting of all menu items has been implemented. The tasting will be performed by the chef and manager on duty. Any items which are not palatable will be revised prior to the meal service " Other options for equipment to keep the food hot will be explored " Lids have been implemented on plates to keep the food hot during	

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F 804	Continued From page 36 Regular Peas/Carrots - tasted bland and the peas were hard Pureed Sloppy Joe - tasted pasty and the flavor did not match the regular texture sloppy joe Pureed Peas/Carrots - tasted bland Mashed Potatoes - tasted bland and floury On 2/11/25 at 1:08 PM, the surveyor informed the US FOIA (b)(6)), of the above findings. The US FOIA (b)(6) stated that "everyone's taste is different," but would prefer the residents to enjoy their meals. Review of the facility's "Food Presentation" policy, undated, included, "Policy: to ensure that food is served in a visually appealing, safe, and consistent manner; to have the food taste and look good."	F 804	transport " Plate warmers have been implemented 4. How the corrective action will be monitored to ensure that the deficient practice does not recur (QA)? Who will be responsible? " The Executive Chef will audit test trays three times per week, for a minimum of three months, at various meals to monitor food temperatures, food palatability and food appearance " The Healthcare Manager will report at the monthly QAPI meeting the results of the test tray audits for a minimum of three months " Based on compliance results, the QAPI committee will determine if the audits and QAPI reports need to continue past the three months	
F 812 SS=F	NJAC 8:39-17.4(a) Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.	F 812		3/28/25

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F 812	Continued From page 37 (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to maintain kitchen sanitation in a safe and consistent manner to prevent food borne illness. This deficient practice was evidenced by the following: On 2/7/25 at 9:50 AM, the surveyor conducted an interview with the US FOIA (b)(6) prior to the initial tour of the kitchen. The US FOIA stated that items stored in the refrigerators and freezers should be labeled and dated with the received date, the opened dated, and the use-by date. The US FOIA further stated that dishware should be inverted and air dried after washing. On 2/7/25 at 10:18 AM, the surveyor, accompanied by the US FOIA observed the following in the kitchen: In the Meat Refrigerator: 1. A shallow two-inch hotel pan of tilapia which was sealed with plastic wrap. The pan was not labeled to identify the food item or dated with a use-by date. At that time, the US FOIA discarded the tilapia. In the Dairy Refrigerator:	F 812	1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? • No residents were found to have been affected by the deficient practice • All outdated, undated or unlabeled items were discarded • All wet pans were identified and re-washed 2. How will you identify other residents having the potential to be affected by the deficient practice and what corrective actions will be taken? • All residents had the potential to be affected by the deficient practice • An inspection was conducted by the Dining Director, on all refrigerators and freezers for labeling and dating compliance • Any undated, outdated or unlabeled items were discarded 3. What measures will be put into place or what system changes will you make to ensure that the deficient practice does not recur? • All dining staff were re-educated on the proper procedure for labeling, dating and discarding outdated items by the Dining Director • The closing Managers will check the	

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F 812	Continued From page 38 2. Asiago cheese which was re-sealed with plastic wrap with a use-by date of 1/21/25. The [redacted] discarded the cheese. 3. A pan of marinara which was sealed with plastic wrap with a use-by date of 1/31/25. The [redacted] discarded the marinara. 4. A one-gallon container of creamed herring which was previously opened. The container was not labeled or dated with an opened or use-by date. The [redacted] discarded the container of creamed herring. 5. A 16-ounce jar of capers which was re-sealed with plastic wrap. The jar was not labeled or dated with an opened or use-by date. The [redacted] discarded the jar of capers. In the Dairy dish drying area: 6. Seven sixth pans stacked on the drying rack which were wet nested. The surveyor lifted the top pan which revealed liquid between the pans. 7. Three third pans stacked on the drying rack which were wet nested. The surveyor lifted the top pan which revealed liquid between the pans. In the Meat dish drying area: 8. Two stacks of hotel pans on the drying rack which were wet nested. The surveyor lifted the top pans of each stack which revealed liquid between the pans. On 2/11/25 at 9:33 AM, the surveyor,	F 812	storage areas in their assigned area for compliance with labeling and dating requirements • All dining staff were re-educated by the Dining Director on the proper procedure for air drying pots and pans • Additional drying racks have been provided to assist with proper air-drying of pots and pans • The Executive Chef will monitor the pot and pan air-drying process daily 4. How the corrective action will be monitored to ensure that the deficient practice does not recur (QA)? Who will be responsible? • The Executive Chef will perform audits three times per week on the refrigerators and freezers for compliance with labeling and dating requirements • The Executive Chef will perform audits three times per week on the air-drying process and ensure no items are wet nested • The Dining Director will present the results of the audits at the monthly QAPI meeting for a minimum of three months • Based on compliance results, the QAPI committee will determine if the audits and QAPI reports need to continue past the three months	

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F 812	Continued From page 39 accompanied by Dietary Service Aide (DSA) #1, observed the following in the freezer portion of the refrigerator located in the Rehab 1 dining room: 9. A three-gallon tub of vanilla ice cream. The lid of ice cream tub was lifted and not properly sealed. The container was not labeled with an opened or use-by date. 10. A three-gallon tub of strawberry ice cream. The lid of the ice cream tub was lifted and not properly sealed. The container was not labeled with an opened or use-by date. 11. Four small, disposable cups covered with lids. The DSA identified the cups as ice cream which was previously portioned out and prepared. The containers were not labeled with a use-by date. At that time, DSA #1 discarded the ice creams. On 2/11/25 at 9:44 AM, the surveyor, accompanied by DSA #2, observed the following in the refrigerator located in the Skilled 2 dining room: 12. A 46-ounce container of nectar thick water which was labeled with a use-by date of 2/9/25. 13. A 46-ounce container of nectar thick lemon-flavored water which was labeled with a use-by date of 1/25/25. At that time, DSA #2 discarded the containers and stated that the DSAs and dietary supervisors were responsible for maintaining the refrigerators in the dining rooms.	F 812		

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F 812	Continued From page 40	F 812		

On 2/11/25 at 9:52 AM, the surveyor, accompanied by DSA #3, observed the following in the refrigerator located in the Rehab 2 dining room:

14. Three 46-ounce containers of nectar thick lemon-flavored water which had an expiration date of 2/3/25.

15. A 46-ounce container of nectar thick water which had an expiration date of 2/3/25.

At that time, DSA #3 discarded the containers and stated the DSAs and dietary supervisors were responsible for checking the refrigerators in the dining rooms.

On 2/11/25 at 10:30 AM, the surveyor interviewed the [US FOIA] who stated the DSAs were responsible for maintaining the refrigerators in the nursing unit dining rooms. The [US FOIA] further stated that the DSAs should check the refrigerators to ensure opened items are labeled with the opened date and use-by date. The [US FOIA] also stated that the DSAs should discard items that are expired or past the use-by date.

On 2/11/25 at 1:08 PM, the surveyor interviewed the [US FOIA (b)(6)] who stated she expected food items to be labeled and dated appropriately, food items to be discarded upon expiration, and pans to be dried according to regulation. The [US FOIA (b)(6)] further stated the dietary staff were responsible for maintaining the dining room refrigerators and should label and date food items appropriately

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F 812	Continued From page 41 and discard expired food items. A review of the facility's "Operational Standards Refrigerator" policy, revised 5/24, included, "Food is properly stored in appropriate containers labeled with product name, date prepared/opened, use-by date and employee initials." A review of the facility's "Refrigerators and Freezers" policy, undated, included, "All food is appropriately dated to ensure proper rotation by expiration dates," and "Expiration dates on unopened food are observed and 'use-by' dates are indicated once food is opened." Further review of the policy included, "Supervisors are responsible for ensuring food items in pantry, refrigerators, and freezers are not past 'use-by' or expiration dates." A review of the facility's "Pots, Pans, Utensils Washing and Air Drying" policy, revised 5/24, included, "All sanitized items must be air dried and cooled completely before stacking and storing."	F 812		
F 880 SS=E	NJAC 8:39-17.2(g) 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.	F 880		3/28/25

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F 880	Continued From page 42 §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; §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	F 880		

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F 880	Continued From page 43 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. §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, and review of facility documents, it was determined that the facility failed to maintain proper infection control practices to ensure a.) staff performed appropriate hand hygiene during meal service for 1 of 4 dining rooms observed (First floor Skilled Nursing Unit), b.) an ice scooper was used to obtain ice from the ice machine during dining observation of 1 of 4 dining rooms observed (First floor skilled nursing unit), c.) ensure NJ Exec Order 26.4b1 equipment was stored in an appropriate way to prevent the spread of infection for 1 of 4 residents reviewed for use of NJ Exec Order 26.4b1 equipment (Resident # 18) and d.) NJ Exec Order 26.4b1 was initiated for 1 of 4 residents (Resident #31) reviewed for infection control. This deficient practice was evidenced by the	F 880	1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? a) Hand Hygiene " Residents #29, 54, 34, 71, 74, 51, 31,37 and 55, will not be served food until staff has performed proper hand hygiene b) Ice Scooper " The residents that were served the cups of ice by DSA #4 and DSA #5 were affected by the deficient practice " Staff will use an ice scooper when getting ice from the ice machine c) NJ Exec Order 26.4b1 Equipment " The NJ Exec Order 26.4b1 equipment for Resident #18 was discarded and replaced with a new piece of equipment d) NJ Exec Order 26.4b1	

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F 880	Continued From page 44 following: 1.) On 2/10/25 at 12:31 PM, the surveyor observed the lunch meal service in the first-floor skilled nursing unit dining room. The surveyor observed the Dietary Service Aide (DSA#5) had removed dirty plates from an unsampled resident at Table #5, scraped the food form the plate into the trash, then proceeded to go into the refrigerator, removed a bottle of juice, poured the juice into a cup and served this juice to another unsampled resident without performing hand hygiene (HH). On 2/11/25 at 8:12 AM, the surveyor observed the following during the breakfast meal service in the first-floor skilled nursing unit dining room. 1. DSA #5 cleaned a blue plastic tray with a rag, then poured coffee for Resident # 74, added cream and sweetener and placed a lid on the coffee cup without performing HH. 2. DSA #5 removed dirty dishes from another table and placed in the cart with the dirty dishes without performing HH. 3.DSA #5 served eggs and toast and jelly to Resident #55 without performing HH. 4. DSA #5 served oatmeal to Resident #29 without performing HH. 5.DSA #5 went to the refrigerator, removed a carton of milk, poured the milk into Resident #54's oatmeal bowl, without performing HH. 6. DSA #5 served the oatmeal to Resident #54, without performing HH. 7. DSA #5 walked to the refrigerator, removed a carton of honey thickened milk, and walked into the satellite kitchen area, poured the [NJ Exec Order 26.4b1] [redacted] into the oatmeal, added in sugar and stirred the oatmeal then served Resident #34 the	F 880	" Resident #31 had completed [NJ E[redacted] [redacted], and the [NJ Exec Order 2[redacted] had been removed prior to the Infection Preventionist being made aware by the survey team that [NJ Exec Order 26.4b1] [redacted] weren't initiated 2. How will you identify other residents having the potential to be affected by the deficient practice and what corrective actions will be taken? a) Hand Hygiene " All residents in the dining room on Skilled 1 had the potential to be affected by the deficient practice " All dining staff were re-educated on proper hand hygiene by the Dining Director b) Ice Scooper " All residents served ice from the ice machine in the Skilled 1 dining room had the potential to be affected by the deficient practice " The ice machine was emptied and sanitized by the company that services the ice machines on 2/25/25 " The dining staff was re-educated on use of an ice scooper to obtain ice from the ice machine by the Dining Director c) Respiratory Equipment " Any resident with respiratory equipment had the potential to be affected by the deficient practice " The Infection Preventionist Nurse will audit for all residents that have respiratory equipment to ensure their equipment is properly stored d) Enhanced Barrier Precautions " Any resident requiring enhanced barrier precautions had the potential to be	

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F 880	Continued From page 45 oatmeal with performing HH.. 8. DSA #5 served oatmeal to Resident #71 without performing HH. 9. DSA #5 poured juice for Resident #34, then served an omelet and toast to Resident #74 without performing HH. 10. DSA #5 served pancakes to Resident #51 without performing HH. 11. Resident #74 requested his/her toast be buttered, DSA #5 then donned (put on) gloves to both hands, buttered the toast, then removed the gloves without performing HH. 12. DSA #5 served an omelet to an unsampled resident without performing HH. 13. DSA#5 served Resident #51 pancakes without performing HH. 14. DSA#5 served Resident #29 pancakes without performing HH On 2/11/25 at 8:55 AM, the surveyor interviewed DSA #5 who stated that hand hygiene should be completed between serving residents. DSA #5 further stated that she washed her hands with soap and water in the sink in the satellite kitchen. On 2/11/25 at 10:03 AM, the surveyor interviewed the US FOIA (b)(6) who stated that hand hygiene should be performed in the dining room in between serving the residents their meals. On 2/11/25 at 10:55 AM, the surveyor interviewed the US FOIA (b)(6) who stated that hand hygiene should be completed in between serving residents their meals. The US FOIA (b) further stated that it was important to use hand hygiene between serving residents to prevent infection or contamination.	F 880	affected by the deficient practice " The Infection Preventionist Nurse will audit all residents with midlines, central lines and indwelling medical devices for enhanced barrier precautions " Any resident found to not have enhanced barrier precautions, will have it initiated immediately 3. What measures will be put into place or what system changes will you make to ensure that the deficient practice does not recur? a) Hand Hygiene " During daily dining department stand up meetings, the dining staff will be educated on proper hand hygiene procedures by the Dining Director " Signs have been placed at all hand washing sinks instructing staff to wash their hands " The facility will ensure hand hygiene supplies are available in all dining rooms b) Ice Scooper " Signs have been placed on the ice machine reminding staff to use the ice scooper when obtaining ice " During daily dining department stand up meetings, the dining staff will be educated to use the ice scooper to obtain ice from the ice machine by the Dining Director c) Respiratory Equipment " Staff will be re-educated on proper storage of respiratory equipment to prevent the spread of infection by the Infection Preventionist Nurse/ADON " The ADON began in-servicing the nursing team on returning to a residents room that's using respiratory equipment	

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F 880	Continued From page 46 On 2/11/25 at 12:15 PM, the surveyor observed the following during the lunch meal in the first-floor skilled unit dining room: 1. DSA #5 served the lunch meal to an unsampled resident without performing HH. 2. At 12:18 PM, DSA #5 assisted Resident #31 put on his/her sweater then served soup to several unsampled residents without performing HH. 3. At 12:25 PM, DSA #5 scraped dirty dishes into the trash, placed the dirty dish into the dishpan then served Resident #37 their lunch meal without performing HH. 4. At 12:27 PM, DSA #5 scraped dirty dishes into the trash, placed the dirty dishes into a dishpan then served Resident #29 their meal without performing HH. A review of facility's "Handwashing/Hand Hygiene" policy, reviewed December 2024 included, "Indications for hand hygiene included: a. immediately before touching a resident, ...c. after touching a resident, after touching a resident's environment, and ...g, immediately after glove removal. A review of facility's "Culinary Services Hand Washing Procedure" revised May 024, included each employee will wash their hands frequently to eliminate visible dirt and to reduce bacterial load and cross contamination Before: ...b. beginning a new task ...and After ....O. removing or changing gloves, P. scraping trays, Q. physical contact with a residents, ... and U. touching equipment such as, refrigerator doors or utensils that have not been cleaned or sanitized.	F 880	upon the completion of the treatment time, to perform cleaning and storage of the equipment. The education began February 12, 2025 and will be completed by March 27, 2025 " Signs will be put on respiratory equipment to remind staff to properly store the equipment " The Respiratory Therapist will in-service the nursing team on cleaning and storing respiratory equipment by March 27, 2025 d) Enhanced Barrier Precautions " The Infection Preventionist Nurse began in-servicing the nursing staff on implementing enhanced barrier precautions. The education began February 12, 2025 and will be completed by March 27, 2025 " The Infection Preventionist Nurse reviewed and updated the facility policy on enhanced barrier precautions, and it was made available to the nursing staff " An enhanced barrier precautions order set will be created and implemented upon ordering of indwelling devices 4. How the corrective action will be monitored to ensure that the deficient practice does not recur (QA)? Who will be responsible? a) Hand Hygiene " The Infection Preventionist Nurse will perform audits at lunch service in all dining rooms, three times per week to ensure staff are performing proper hand hygiene " The Healthcare Manager will perform audits at breakfast and dinner service in all dining rooms, three times per week to	

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F 880	Continued From page 47 2.) On 02/10/25 at 12:20 PM, the surveyor observed the following during the lunch meal service in the first-floor skilled nursing unit dining room. The surveyor observed DSA #4 used a plastic drinking cup and with her bare hand, reached into the ice machine and scooped the ice into the plastic cup. At 12:29 PM, the surveyor observed DSA #4 again used a plastic drinking cup with her bare hand, reached into the ice machine and scooped the ice into the plastic cup. On 2/11/25 at 9:24 AM, the surveyor interviewed DSA #4 who stated that an ice scooper should be used to dispense ice form the ice machine. DSA #4 further stated that a plastic cup should never be used in the ice machine to obtain the ice. On 2/11/25 at 12:22PM, the surveyor observed DSA #5 during the breakfast meal service in the first-floor skilled nursing unit dining room. The surveyor observed DSA #5 used a resident plastic drinking cup with her bare hand, reached into the ice machine and scooped the ice into the plastic cup. On 2/11/25 at 10:55 AM, the surveyor interviewed the [US FOIA (b)] who stated that an ice scooper should be used when getting ice from the ice machine. The [US FOIA (b)] further stated that it was important to use an ice scooper to remove ice from the ice machine to prevent the spread of infection or contamination. On 1/13/25, the facility provide the surveyor an in-service titled "Ice Scoop Training" which included that ice scoops are to be used in all ice machines for safety ...2. Ice scoops are the only	F 880	ensure staff are performing proper hand hygiene " The Infection Preventionist Nurse will report audit findings at the monthly QAPI meeting for a minimum of three months " Based on compliance results, the QAPI committee will determine if the audits and reports need to continue past the three months " The Healthcare Manager will report audit findings at the monthly QAPI meeting for a minimum of three months " Based on compliance results, the QAPI committee will determine if the audits and reports need to continue past the three months b) Ice Scooper " The Infection Preventionist Nurse will perform audits at lunch service in all dining rooms, three times per week to ensure staff are using the ice scooper to obtain ice from the ice machine " The Healthcare Manager will perform audits at breakfast and dinner service in all dining rooms, three times per week to ensure staff are using the ice scooper to obtain ice from the ice machine " The Infection Preventionist Nurse will report audit findings at the monthly QAPI meeting for a minimum of three months " Based on compliance results, the QAPI committee will determine if the audits and reports need to continue past the three months " The Healthcare Manager will report audit findings at the monthly QAPI meeting for a minimum of three months " Based on compliance results, the QAPI committee will determine if the	

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F 880	Continued From page 48 tool to use when getting ice from the ice machine, 3. DO NOT use- glasses, cups, spoons, plastic cups or anything that is NOT an ice scoop. A review of the facility's Infection Prevention and Control" policy revised December 2024, included S. Infection prevention and control program (IPCP) refers to a program (including surveillance, investigation, prevention, control and reporting) that provides a safe, sanitary and comfortable environment to help prevent the development and transmission of infection." 3.) On 2/7/25 at 10:37 AM, during the initial tour of the first-floor skilled nursing unit, the surveyor observed Resident #18 NJ Exec Order 2 and NJ Exec O sitting in his/her wheelchair in their room. The surveyor observed a NJ Exec Order 26.4b1 lying directly on the bedside table, not stored in a plastic bag. On 2/11/2025 at 10:09 AM, the surveyor observed Resident #18 sitting in his/her wheelchair in his/her room with their eyes closed. The surveyor observed a NJ Exec Order 26.4b1 mask lying directly on the bedside table, not stored in a plastic bag On 2/11/2025 at 10:10 AM, the surveyor interviewed the Licensed Practical Nurse (LPN #3) who stated Resident #18 used the NJ Exec Order 26.4b1 as needed and would ask for it if needed. LPN #3 also stated that after using the NJ Exec Order 26.4b1 NJ Exec Order the NJ Exec Orde should be cleaned and then stored in a plastic bag. LPN #3 confirmed that the NJ Exec Order 26.4b1 in Resident #18's room was not stored in a	F 880	audits and reports need to continue past the three months c) Respiratory Equipment " The Infection Preventionist Nurse will perform audits three times per week on residents that have respiratory equipment to ensure the equipment is properly stored " The Infection Preventionist Nurse will report audit findings at the monthly QAPI meeting for a minimum of three months " Based on compliance results, the QAPI committee will determine if the audits and reports need to continue past the three months d) Enhanced Barrier Precautions " The Infection Preventionist will review the 24-hour report and daily manager/supervisor reports for residents that should be placed on enhanced barrier precautions " The Infection Preventionist Nurse will perform audits three times per week on residents that require enhanced barrier precautions to ensure the precautions have been initiated " The Infection Preventionist Nurse will report audit findings at the monthly QAPI meeting for a minimum of three months " Based on compliance results, the QAPI committee will determine if the audits and reports need to continue past the three months	

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plastic bag. LPN #3 further stated that it was important to store the NJ Exec Order 26.4b1, when not in use, in a plastic bag for infection control.

On 2/11//2025 at 1:40 PM, the surveyor reviewed the medical record for Resident #18.

A review of the admission record, an admission summary, revealed the resident had diagnosis which included, NJ Exec Order 26.4b1 .

A review of the quarterly Minimum data Set (MDS), an assessment tool, dated NJ Exec Order 26.4, included the resident had a Brief Interview for mental status (BIMS) score of NJ Exe out of 15, which indicated the resident's NJ Exec Order 26.4b1.

A review of the the physician's orders (PO) for Resident #18, which included the following:

A PO, dated NJ Exec Order 26.4b1, for NJ Exec Order 26.4b1 every 6 hours as needed for NJ Exec Order 26.4b1

A review of the individual comprehensive care plan (ICCP) included a focus area, dated NJ Exec Order 26.4b1, that the resident had NJ Exec Order 26.4b1 Interventions included: to give medications (meds) as ordered.

On 2/12/2025 at 12:15 PM, the surveyor interviewed the US FOIA (b) who stated that after use, the NJ Exec Order 26.4b1 should be cleaned, dry at room air, then stored and maintained in a plastic bag. The US FOIA (b) also stated that this was important to store the NJ Exec Order 26.4b1 in a plastic bag when not in

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use to prevent contamination from the environment.

A review of the facility's undated "Nebulizer Therapy Policy" included, "Procedures ...3. Equipment Maintenance and Safety...Nebulizer mask and tubing shall be stored in a plastic bag when not in use and replaced weekly."

4.) On 02/07/25 at 10:34 AM, the surveyor observed Resident #31 NJ Exec Order 2 and NJ Exec Orde sitting in a wheelchair in their room. The surveyor observed an NJ Exec Order 26.4b1 located in the resident's room. Resident #31 stated that he/she had an NJ Exec Order 26.4b1 in his/her NJ Exec Order 26.4b1 about four (4) days ago for a NJ Exec Order 26.4b1 . NJ Exec Order 26.4b1 signage was observed posted inside or outside the resident's room.

On 2/10/25 at 12:22 PM, the surveyor observed Resident #31 not in his/her room. At that time, the surveyor observed an empty bag of NJ Exec Order 26.4b1 medication NJ Exec Order 26.4b from the NJ Exec Order 26 in the resident's room. No NJ Exec Or signage was observed posted inside or outside the resident's room.

The surveyor reviewed the medical record for Resident #31.

A review of the Admission Record, an admission summary, revealed the resident had diagnosis which included, NJ Exec Order 26.4b1

A review of the resident's quarterly MDS, dated

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F 880	Continued From page 51 NJ Exec Order 26 included the resident had a BIMS score of NJ Exec which indicated the resident's NJ Exec Order 26.4b1 was NJ Exec Order Further review of the MDS revealed the resident was always NJ Exec Order 26.4b1. A review of the ICCP included a focus area, dated NJ Exec Order 26.4b1, that the resident had an infection of the NJ Exec Order 26.4b1. Interventions included: administer NJ Ex Order 26.4b1 per medical doctor (MD) orders. The care plan did not include NJ Exec Orde A review of the Order Summary Report (OSR), dated as of NJ Exec Order 26, included the following physician's orders (PO): A PO, dated NJ Exec Order 2, for NJ Exec Order 26.4b1. A PO, dated NJ Exec Order 2, to check NJ Exec Order 26.4b1 every shift for signs and symptoms of NJ Exec Order 26.4b every shift A PO, dated NJ Exec Order 26.4 to start on NJ Exec Order 26 for NJ Exec Order 26.4b1 Use NJ Exec Order 26.4b1 two times a day related to NJ Exec P for 7 days, with end date of NJ Exec Order 26.4b A PO, dated NJ Exec Order 26.4b to NJ Exec Order 26.4b1 A review of the NJ Exec Order 26.4b1 Documentation form from an outside company, dated NJ Exec Order 26, indicated the NJ Exec Order 26 was placed to the NJ Exec O On 2/11/2025 at 10:03 AM, surveyor interviewed the US FOIA (b)(6)) who stated that a resident who had a NJ Exec Order 26.4b1 should be on NJ Exec Orde The US F stated that Resident # 31 was not on NJ Exec O because she thought the resident had a NJ Exec Order 26.4b1 not a NJ Exec Order 26.4b1.	F 880		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 52 On 2/12/2025 at 12:15 PM, the surveyor interviewed the [redacted] who stated that a resident who had a NJ Exec Order 26.4b1 should be on [redacted] Reference: Center for Disease Control and Prevention, Long-Term Care Facilities, document titled "Frequently Asked Questions (FAQs) about Enhanced Barrier Precautions in Nursing Homes" dated June 28, 2024, states, " ...22. What is the definition of "indwelling medical device"? An indwelling medical device provides a direct pathway for pathogens in the environment to enter the body and cause infection. Examples of indwelling medical devices include, but are not limited to, central vascular catheters (including hemodialysis catheters, peripherally inserted central catheters (PICCs)) ... Although the data are limited, CDC does not currently consider peripheral I.V.s (except for midline catheters) ... as indications for Enhanced Barrier Precautions ..." A review of the facility's "Enhanced Barrier Precautions (EBP)" policy, reviewed December 2024, included, EBP are required for patients with any of the following: 2. Indwelling medical devices: Midlines, PICC lines, Central lines. NJAC 8:39-19.4(n)	F 880		

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
	04002	A. BUILDING: _____ B. WING _____	C 02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIONS GATE	1100 LAUREL OAK ROAD VOORHEES, NJ 08043

(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 is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency 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		
S2315	8:39-31.6(i)(1-2) Mandatory Physical Environment (i) The administrator shall serve as, or appoint, a disaster planner for the facility. 1. The disaster planner shall meet with county and municipal emergency management coordinators at least once each year to review and update the written comprehensive evacuation plan, or if county or municipal officials are unavailable for this purpose, the facility shall notify the State Office of Emergency Management. 2. While developing the facility's evacuation plan, the disaster planner shall coordinate with the facility or facilities designated to receive relocated residents. This REQUIREMENT is not met as evidenced	S2315		3/28/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 03/07/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04002	A. BUILDING: _____ B. WING _____	C 02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIONS GATE	1100 LAUREL OAK ROAD VOORHEES, NJ 08043

(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
S2315	Continued From page 1 by: Based on record review and interview on 2/11/25 in the presence of the Administrator, it was determined the facility failed to meet with county and municipal emergency management coordinators at least once each year to review and update the written comprehensive evacuation plan, or if county and municipal officials are unavailable, the facility shall notify the State Office of Emergency Management. This deficient practice had the potential to affect all residents and was evidenced by the following: A record review of the facility's mandatory emergency preparedness documents revealed there was no documentation of annual review of the emergency preparedness plan by municipal, county or state, Office of Emergency Management officials in the past 12 months. In an interview at the time, the Administrator confirmed the record review. The facilities Administrator was informed of the deficient practice at the Life Safety Exit conference at 3:20 PM.	S2315	1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? " No residents were found to have been affected by the deficient practice • The Administrator emailed the Emergency Management Coordinator of the Camden County Department of Public Safety on March 11, 2025 – see attached email evidence 2. How will you identify other residents having the potential to be affected by the deficient practice and what corrective actions will be taken? " No residents were found to have been affected by the deficient practice " The facility has an emergency preparedness manual 3. What measures will be put into place or what system changes will you make to ensure that the deficient practice does not recur? " The Administrator will reach out to county and municipal emergency management coordinators at least once each year to review and update the written comprehensive evacuation plan " If the county and municipal officials are unavailable, the Administrator will notify the State Office of Emergency Management " The Administrator will document their attempts to reach the above offices 4. How the corrective action will be monitored to ensure that the deficient practice does not recur (QA)? Who will be responsible? " The Administrator will set a calendar	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04002	A. BUILDING: _____ B. WING _____	C 02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIONS GATE	1100 LAUREL OAK ROAD VOORHEES, NJ 08043

(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
S2315	Continued From page 2	S2315	reminder to reach out to the county and municipal emergency management coordinators every March " If the county and municipal emergency management coordinator don□t respond withing 14 days, the Administrator will reach out again " The Administrator will set a calendar reminder to reach out to the State Office of Emergency Management if the county and municipal managers don□t respond " The Administrator will report their attempts to reach the county, municipal and State offices to the QAPI committee monthly until a meeting has been scheduled	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
315499		4/2/2025

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LIONS GATE	1100 LAUREL OAK ROAD VOORHEES, NJ 08043

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 F0609 Reg. # 483.12(b)(5)(i)(A)(B)(c)(1)(4) LSC	Correction Completed 03/28/2025	ID Prefix F0755 Reg. # 483.45(a)(b)(1)-(3) LSC	Correction Completed 03/28/2025	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	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 2/13/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

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
315499 Y1	A. Building B. Wing Y2	4/2/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LIONS GATE	1100 LAUREL OAK ROAD VOORHEES, NJ 08043

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 F0550	Correction	ID Prefix F0609	Correction	ID Prefix F0656	Correction
Reg. # 483.10(a)(1)(2)(b)(1)(2)	Completed	Reg. # 483.12(b)(5)(i)(A)(B)(c)(1)(4)	Completed	Reg. # 483.21(b)(1)(3)	Completed
LSC	03/28/2025	LSC	03/28/2025	LSC	03/28/2025
ID Prefix F0692	Correction	ID Prefix F0755	Correction	ID Prefix F0804	Correction
Reg. # 483.25(g)(1)-(3)	Completed	Reg. # 483.45(a)(b)(1)-(3)	Completed	Reg. # 483.60(d)(1)(2)	Completed
LSC	03/28/2025	LSC	03/28/2025	LSC	03/28/2025
ID Prefix F0812	Correction	ID Prefix F0880	Correction	ID Prefix	Correction
Reg. # 483.60(i)(1)(2)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. #	Completed
LSC	03/28/2025	LSC	03/28/2025	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?
2/13/2025	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
04002 Y1	A. Building B. Wing Y2	4/2/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LIONS GATE	1100 LAUREL OAK ROAD VOORHEES, NJ 08043

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 S2315 Reg. # 8:39-31.6(i)(1-2) LSC	Correction Completed 03/28/2025	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
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 2/13/2025	☐ 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
	315499	A. BUILDING **01** B. WING _____	**02/13/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIONS GATE	**1100 LAUREL OAK ROAD** **VOORHEES, NJ 08043**

(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 2/10/25 and 2/11/25. Lions Gate 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. Lions Gate is a Type II protected construction building. The facility is divided into 12 smoke zones. The 500 kw exterior diesel generator approximately 100% of the building. The LTC and Rehabilitation areas are served by wet sprinkler systems. There are 6 fire hydrants on the property that the facility maintains and inspects. The facility has 110 licensed beds and had a census of 101 residents.	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	K 324		3/28/25

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

Electronically Signed | 03/07/2025

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
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K 324	Continued From page 1 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 * 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 observation and interview on 02/10/2025 in the presence of the [US FOIA (b)(6)] [redacted], it was a determined that the facility failed to perform monthly owners inspections of the range-hood fire wet chemical suppression systems in accordance with NFPA 17 A: 2009 Edition, Section 7.2, 7.2.1 to 7.2.6 and NFPA 96: 2011 Edition, Sections 11.2.1 and 11.2.3. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 12:52 PM of the kitchen range-hood fire suppression system wet chemical inspection tag, revealed the semi-annual inspection was performed on October 2024 and there were no monthly inspections listed. The	K 324	1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? " No residents were found to have been affected by the deficient practice 2. How will you identify other residents having the potential to be affected by the deficient practice and what corrective actions will be taken? " All residents had the potential to be affected by the deficient practice " The maintenance department will perform monthly owners inspections of the range-hood fire wet chemical suppression system " The owners inspection of the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315499	A. BUILDING 01 B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 324	Continued From page 2 facility did not have the monthly inspection documentation indicating the monthly owners inspection had been performed for the previous 12 months. No further documentation was provided. In an interview at the time, the [US FOIA (b)] confirmed the observation and stated they didn't do an owners inspection. The [US FOIA (b)(6)] was informed of the deficient practice at the Life Safety Code exit conference on 02/11/2025 at 3:20 PM. NJAC 8:39-31.2(e) NFPA 17 A, 96	K 324	range-hood fire wet chemical suppression system was conducted for the month of March 3. What measures will be put into place or what system changes will you make to ensure that the deficient practice does not recur? • The Director of Property and Maintenance has started in-servicing the maintenance staff on conducting monthly owner inspections of the range-hood fire wet chemical suppression system. Education began on March 4, 2025 and will be completed by March 25, 2025 " The monthly inspection of the range-hood fire wet chemical suppression system will be added to the life safety binder and checked as part of the preventative maintenance for building systems " The maintenance department will document the monthly inspection of the range-hood fire wet chemical suppression system on the inspection tag 4. How the corrective action will be monitored to ensure that the deficient practice does not recur (QA)? Who will be responsible? " The Director of Property and Maintenance will check the inspection tag monthly, every month, to ensure the owners inspection occurred and was documented. The Director of Property and Maintenance will document their inspection on the preventative inspection log monthly • The Director of Property and Maintenance will report at the monthly QAPI meetings, that the monthly owners	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315499	A. BUILDING 01 B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 324	Continued From page 3	K 324	inspection occurred, for a minimum of three months • Based on compliance results, the QAPI committee will determine if the Director of Property and Maintenance needs to continue reporting after the three months " The Director of Property and Maintenance will keep the previous inspection tags for a minimum of 2 years as proof of monthly inspection	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on observations and interviews from 02/10/2025 to 02/11/2025 in the presences of the US FOIA (b)(6)), it was determined that the facility failed to ensure that fire and smoke door assemblies were inspected and tested annually with written record in accordance with NFPA 80: 2010 Edition	K 761	1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? " No residents were found to be affected by the deficient practice 2. How will you identify other residents	3/28/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315499	A. BUILDING 01 B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 761	Continued From page 4 Sections 5.2.1, 5.2.3, 5.2.4.2 (1) through (11), NFPA 105:2010 Edition, and NFPA 101: 2012 Edition, Sections 7.2.1.15.1 to 7.2.1.15.8, 8.3.3.1, and 19.7.6. This deficient practice had the potential to affect all residents and was evidenced by the following: A record review on 02/10/2025 and 02/11/2025 revealed there was no documentation that annual inspections of fire door assemblies were conducted and no documentation that inspections of smoke door assemblies were conducted as part of the facilities maintenance program. In an interview at the time, the US FOIA (b) confirmed the observation and stated that they did inspections but did not keep a written record of the inspections. The US FOIA (b)(6) was informed of the deficient practices at the Life Safety Code Exit conference on 02/11/2025 at 3:20 PM. N.J.A.C 8:39-31.2 (e) NFPA 80, 101, 105	K 761	having the potential to be affected by the deficient practice and what corrective actions will be taken? " No residents had the potential to be affected by the deficient practice " Monthly fire drills are conducted by an outside vendor and the fire doors are engaged during the drills to ensure they□re working properly, reports are received from the vendor and kept in the Life Safety Book " The Director of Property and Maintenance did perform an annual inspection of the fire doors but failed to document the inspection in the year 2024 3. What measures will be put into place or what system changes will you make to ensure that the deficient practice does not recur? " An inspection of the fire doors was conducted on 1/28/2025 by the company that conducts our monthly fire drills - see attached letter of inspection " The company that conducts our monthly fire drills will conduct an inspection of the fire doors annually • An inspection of the smoke door assemblies is scheduled for 3/15/2025 by the company that conducts our monthly fire drills • The Director of Property and Maintenance has started in-servicing the maintenance staff on scheduling the inspection of the fire doors and smoke door assemblies annually. The education began on March 4, 2025 and will be completed by March 25, 2025 • The company that conducts our monthly fire drills will conduct an	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315499	A. BUILDING **01** B. WING _____	**02/13/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIONS GATE	**1100 LAUREL OAK ROAD** **VOORHEES, NJ 08043**

(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 761	Continued From page 5	K 761	inspection of the fire doors and smoke door assemblies annually " The Director of Property and Maintenance will no longer be responsible for conducting the inspection 4. How the corrective action will be monitored to ensure that the deficient practice does not recur (QA)? Who will be responsible? " The annual inspection of the fire doors will be added to the life safety binder and checked as part of the preventative maintenance for building systems " The report for the annual testing of the fire doors and smoke door assemblies will be added to the life safety binder and reviewed annually for completion " The Director of Property and Maintenance will report at the monthly QAPI meetings what inspections have been completed for the current month, what the outcome of the inspection was and what inspections are due for next month. The Director of Property and Maintenance will report on inspections until the annual inspection of the fire doors and smoke door assemblies has been completed for the current year	
K 918 SS=F	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	K 918		3/28/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315499	A. BUILDING 01 B. WING _____	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIONS GATE	1100 LAUREL OAK ROAD VOORHEES, NJ 08043

(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 6 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 observation, documentation review and interviews on 02/10/2025 and 02/11/2025 in the presence of the US FOIA (b)(6) [redacted] it was determined the facility failed to 1. Ensure the diesel fueled emergency power generator was exercised at a load equal to or greater than 30% of its name plate rating during the monthly full load tests or conduct an annual 90 minute load bank test and 2. Provide	K 918	a) Emergency Power Generator 1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? " No residents were found to have been affected by the deficient practice 2. How will you identify other residents having the potential to be affected by the	

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K 918	Continued From page 7 battery powered emergency lighting at Emergency Power Supply (EPS) equipment locations in accordance with NFPA 110: 2010 Edition, Sections 8.4, 8.4.2, 8.4.2.3 and 7.3.1. This deficient practice had the potential to affect all residents and was evidenced by the following: 1. A documentation review on 02/11/2025 of the emergency power generator's inspection, testing and maintenance logs revealed the generator was exercised under full load each month for the last 12 months. No load value for the percentage of the nameplate rating was recorded to indicate the generator was exercised at 30% or greater of its nameplate Kilowatt rating. There was no report that a 90 minute annual load bank test was performed in the last 12 months. In an interview at the time, the [redacted] confirmed the documentation review and stated that he thought the facilities generator service did a 4 hour load bank test every year. No further documentation was provided. 2. An observation on 02/10/2025 at 1:10 PM revealed the generator's Transfer Switch (TS) was located in a mechanical room that was not equipped with battery powered emergency lighting at the TS location. In an interview at the time, the [redacted] confirmed the observation. The [redacted] was informed of the deficient practices during the Life Safety Code exit conference on 02/11/2025 at 3:20 PM. NJAC 8:39-31.2(e) NFPA 99, 110	K 918	deficient practice and what corrective actions will be taken? " No residents were found to have the potential to be affected by the deficient practice " Weekly generator testing is performed and documented " Monthly generator testing is performed and documented " Quarterly generator testing is performed and documented " Semi-annual generator testing is performed and documented " Annual generator testing is performed and documented 3. What measures will be put into place or what system changes will you make to ensure that the deficient practice does not recur? " The annual 90-minute load bank test will be added to the life safety binder and checked as part of the preventative maintenance for building systems " The generator company we utilize will come out on an annual basis and perform a 90-minute load bank test " The annual 90-minute load bank test has been scheduled for 3/12/25 - see attached • The Director of Property and Maintenance has started in-servicing the maintenance staff on scheduling the 90-minute load bank test. Education began on March 4, 2025 and will be completed by March 25, 2025 4. How the corrective action will be monitored to ensure that the deficient practice does not recur (QA)? Who will be responsible?	

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	315499	A. BUILDING **01** B. WING _____	**02/13/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIONS GATE	**1100 LAUREL OAK ROAD** **VOORHEES, NJ 08043**

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K 918	Continued From page 8	K 918	" The Director of Property and Maintenance will report at the monthly QAPI meetings what inspections have been completed for the current month, what the outcome of the inspection was and what inspections are due for next month.The Director of Property and Maintenance will report on inspections until the annual 90-minute load bank test has been completed for the current year b) Battery powered emergency lighting at emergency power supply equipment 1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? " No residents were found to have been affected by the deficient practice 2. How will you identify other residents having the potential to be affected by the deficient practice and what corrective actions will be taken? " No residents were found to have the potential to be affected by the deficient practice 3. What measures will be put into place or what system changes will you make to ensure that the deficient practice does not recur? " Battery powered emergency lighting was installed at the emergency power supply equipment on 2/20/25- see attached proof " The battery powered emergency lighting at the emergency power supply has been added to the monthly emergency lighting preventative maintenance checks performed by the maintenance department	

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	315499	A. BUILDING **01** B. WING _____	**02/13/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIONS GATE	**1100 LAUREL OAK ROAD** **VOORHEES, NJ 08043**

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K 918	Continued From page 9	K 918	" Monthly checks will be documented in the preventative maintenance emergency lighting book 4. How the corrective action will be monitored to ensure that the deficient practice does not recur (QA)? Who will be responsible? " The Director of Property and Maintenance will perform monthly checks, for a minimum of three months, to ensure the maintenance department performed their monthly checks of the emergency lighting " The Director of Property and Maintenance will report at the monthly QAPI meetings for a minimum of three months, that the monthly emergency lighting checks have been completed • Based on compliance results, the QAPI committee will determine if the Director of Property and Maintenance needs to continue reporting after the three months	

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)
315499	A. Building 01 - LIONS GATE B. Wing	4/2/2025

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LIONS GATE	1100 LAUREL OAK ROAD VOORHEES, NJ 08043

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 K0324	Correction Completed 03/28/2025	ID Prefix Reg. # NFPA 101 LSC K0761	Correction Completed 03/28/2025	ID Prefix Reg. # NFPA 101 LSC K0918	Correction Completed 03/28/2025
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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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	
2/13/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO