STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04A003	A. BUILDING: _____ B. WING _____	C 11/13/2025

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
A 000	Initial Comments Initial Comments: COMPLAINT #: NJ00163220, NJ00165868, NJ00169414, NJ00179962, NJ00180626, NJ00189180. CENSUS: 59 SAMPLE SIZE: 8 TYPE OF SURVEY: Standard, Complaint, and Life Safety Code Survey of 70 residential units The facility is not in substantial compliance with all the standards in the New Jersey Administrative Code 8:36, Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes, and Assisted Living Programs. 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 provisions of New Jersey Administrative Code Title 8, Chapter 43E, Enforcement of Licensure Regulations. A Life Safety Code Survey was conducted by the State Agency on 11/12/2025- 11/13/2025. The facility was not in substantial compliance with New Jersey Administrative Code, Chapter 8:36, Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes, and Assisted Living Programs.	A 000		
A 310	8:36-3.4(a)(1) Administration (a) The administrator or designee shall be responsible for, but not limited to, the following: 1. Ensuring the development, implementation, and enforcement of all policies	A 310		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 01/05/26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 310	Continued From page 1 and procedures, including resident rights; This REQUIREMENT is not met as evidenced by: Complaint #NJ00169414 and #NJ00189180 Based on record review, interview, and facility policy review, the facility failed to implement the "Abuse Policy," and ensure that a thorough investigation of an NJ Exec Order 26.4b1 was conducted for 2 (Resident #2 and Resident #4) of 4 residents reviewed for NJ Exec Order 26.4b1. Findings included: An undated facility policy titled, "Abuse Policy," revealed, "Investigation: All allegations of abuse will be promptly and thoroughly investigated." 1. An "Admission Record" indicated the facility admitted Resident #2 on NJ Exec Order 26.4b1. According to the Admission Record, the resident had a medical history that included diagnoses of NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1. Resident #2's "Service Plan Report" included a focus area initiated NJ Exec Order 26.4b1 that revealed the resident had NJ Exec Order 26.4b1 or NJ Exec Order 26.4b1 related to	A 310		

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A 310	Continued From page 2 NJ Exec Order 26.4b1 Interventions directed staff to keep NJ Exec Order 26.4b1 as needed, keep the resident's NJ Exec Order 26.4b1, and try to provide consistent care givers as much as possible in order to NJ Exec Order 26.4b1 (initiated NJ Exec Order 26.4b1 Resident #2's "Progress Notes" dated NJ Exec Order 26.4b1 at 11:37 AM revealed a "Physician's Progress Note" that indicated the physician saw the resident at the family's "behest" due to "weekend events." The notes revealed the resident's family member reported that on NJ Exec Order 26.4b1 the resident was "NJ Exec Order 26.4b1," because "apparently something happened between the [resident] and [the resident's] private aide, and there was an NJ Exec Order 26.4b1 Per the notes, Resident #2 was a NJ Exec Order 26.4b1 due to their NJ Exec Order 26.4b1 A "Reportable Event Record/Report" dated NJ Exec Order 26.4b1, submitted by the Chief Operating Officer (COO), revealed that on NJ Exec Order 26.4b1 at 5:30 PM, Private Care Giver (PCG) #22 (a private duty aide hired by the resident's family) NJ Exec Order 26.4b1 was NJ Exec Order 26. with Resident #2 when trying to get the resident NJ Exec Order 26.4b1. Per the report, PCG #22 NJ Exec Order 26.4b the resident's NJ Exec Orde and NJ Exec Order 26.4b1 to NJ Exec Order 26.4b1 from a NJ Exec Orde The report revealed that the resident became NJ Exec Order 26.4 because they did not want to be NJ Exec Order 26.4b into their NJ Exec Order 26.4b1 According to the report, as a result of trying to get PCG #22 to NJ Exec Order 26.4b1, Resident #2 NJ Exec Order 26.4b1 PCG's NJ Exec from their NJ Exec Ord The report revealed Resident #2 reported the incident to the receptionist at the front desk. At the same time, PCG #22 sent a text to Resident #2's family member informing them that she was NJ Exec Order 26 because she could not take any more NJ Exec Order from Resident #2. According to the report, NJ Exec Order 26.4b1 were noted to Resident #2.	A 310		

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A 310	Continued From page 3 Per the report, the facility reported the incident to PCG #22's employer and requested both verbally and in writing that NJ Exec Order 26.4b1. The facility's investigation revealed they obtained a statement from the receptionist; however, there was no documented evidence that the facility obtained an interview/statement from staff working during the time of the incident, the resident, or the NJ Exec Order 26.4b1. On 11/13/2025 at 9:57 AM, the Nurse Manager (NM) stated that when an NJ Exec Order 26.4b1 was brought to her attention, she initiated an investigation, which included speaking to involved staff members, the resident, and family. However, the NM stated that she was not involved with the investigation. On 11/12/2025 at 12:26 PM, the COO stated she did not remember whether she spoke with PCG #22 or other staff. On 11/13/2025 at 10:23 AM, the COO stated that Resident #2 and PCG #22 both reported NJ Exec Order 26.4b1. She stated that generally she asked staff whether anyone overheard anything or whether someone told them something; however, she did not remember whether she spoke with staff regarding this NJ Exec Order 26.4b1 2. An "Admission Record" revealed the facility admitted Resident #4 on NJ Exec Order 26.4b1. According to the Admission Record, the resident had a medical history that included diagnoses of NJ Exec Order 26.4b1, NJ Ex Order 26.4(b)(1) and NJ Exec Order 26.4b1 Resident #4's "Service Plan" included a focus area initiated NJ Exec Order 26.4b1 that indicated the	A 310		

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A 310	Continued From page 4	A 310		

resident needed NJ Exec Order 26.4b1 with activities of daily living (ADL care) due to NJ Exec Order 26.4b1. Interventions directed staff to NJ Exec Order 26.4b1 the resident if NJ Exec Order 26.4b1 was NJ Exec Order 26.4b1 (initiated NJ Exec Order 26.4b1; monitor the resident for NJ Exec Order 26.4b1 signs of NJ Exec Order 26.4b1 such as NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 and notify the nurse if it occurred (initiated NJ Exec Order 26.4b1); and for the resident's private aide to assist with care, NJ Exec Order 26.4b1, and bring to the television lounge before leaving in the morning (initiated NJ Exec Order 26.4b1.

A "Reportable Event Record/Report," dated NJ Exec Order 26.4b1 revealed that on NJ Exec Order 26.4b1 at approximately 11:30 PM, CHHA #3 witnessed Private Care Giver (PCG) #14, a PCG hired by the resident's family, tell Resident #4, "NJ Exec Order 26.4b1 The CCHA reported that PCG #14 then removed a NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 from her purse, began NJ Exec Order 26.4b1, and went to the refrigerator to mix the tablet in ice cream. Per the report, CHHA #3 left the room. The report further revealed that on NJ Exec Order 26.4b1 at approximately 6:45 AM, PCG #14 told CHHA #3 that Resident #4 had NJ Exec Order 26.4b1 in the NJ Exec Order 26.4b1 twice during the night and that she "NJ Exec Order 26.4b1 [Resident #4] NJ Exec Order 26.4b1 but checked [the resident] to make sure [the resident] doesn't have any NJ Exec Order 26.4b1 The Reportable Event Record/Report revealed Resident #4 was assessed following the NJ Exec Order 26.4b1 and had NJ Exec Order 26.4b1. The Reportable Event Record/Report also revealed that Resident #4's representative (RR) #17 NJ Exec Order 26.4b1 PCG #14's employment and the PCG was placed on a NJ Exec Order 26.4b1 for the facility. The report revealed that the facility determined that PCG #14's NJ Exec Order 26.4b1 was NJ Exec Order 26.4b1 and posed potential risk to the resident's safety and well-being.

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A 310	Continued From page 5 During an interview on 11/13/2025 at 3:55 PM, the Chief Operating Officer (COO) stated that since PCG #14 was not a staff member and was not returning to the facility, they did not feel they needed to interview PCG.	A 310		
A 389	8:36-4.1(a)(16) Resident Rights (a) Each assisted living provider will post and distribute a statement of resident rights for all residents of assisted living residences, comprehensive personal care homes, and assisted living programs. Each resident is entitled to the following rights: 16. The right to be free from physical and mental abuse and/or neglect; This REQUIREMENT is not met as evidenced by: Complaint # NJ00179962 and NJ00189180 Based on interview, record review, and facility policy review, the facility failed to protect the residents' right to be [redacted] from [redacted] for 2 (Resident #3 and Resident #4) of 4 residents sampled for NJ Exec Order 26.4b1 Findings included: An undated facility policy titled "Abuse Prevention Program" revealed, "As part of the resident abuse prevention, the administration will: 1. Protect our residents from abuse by anyone including, but not necessarily limited to: facility staff, other	A 389		

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A 389	Continued From page 6	A 389		

residents, consultants, volunteers, staff from other agencies, family members, legal representatives, friends, visitors, or any other individual."

1. An "Admission Record" revealed the facility admitted Resident #3 on NJ Exec Order 26.4b1. According to the Admission Record, the resident had a medical history that included diagnoses of NJ Exec Order 26.4b1, NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1.

Resident #3's "Service Plan," included a focus area initiated NJ Exec Order 26.4b1, that indicated the resident had activities of daily living (ADL) care needs related to NJ Exec Order 26.4b1. Interventions directed staff to NJ Exec Order 26.4b1 the resident if they NJ Exec Order 26.4b1 care and notify the nurse (revised NJ Exec Order 26.4b1).

Resident #3's "Progress Note" revealed an "Incident Note," documented by Licensed Practical Nurse (LPN) #1, with an effective date of NJ Exec Order 26.4b1 at 7:45 AM. The note revealed that a Certified Homemaker-Home Health Aide (CHHA) reported that Resident #3 NJ Exec Order 26.4b1 while she was attempting to assist the resident with their NJ Exec Order 26.4b1 and the CHHA NJ Exec Order 26.4b1 the resident's NJ Exec Order 26.4b1. Per the note, Resident #3 stated they did not recall what happened but stated, "I know there was a NJ Exec Order 26.4b1 if she is going to complain about me then I am going to complain about her." The Incident Note revealed LPN #1 assessed Resident #3 and the resident had NJ Exec Order 26.4b1.

A "Reportable Event Record/Report," dated NJ Exec Order 26.4b1, revealed that on NJ Exec Order 26.4b1 at 7:15

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A 389	Continued From page 7	A 389		

AM, CHHA #9 reported to the day shift LPN that she had an NJ Exec Order 26.4b1 with Resident #3. As a result of the NJ Exec Order 26.4b1 the CHHA NJ Exec Order 26.4b1 the resident's NJ Exec Order 26.4b1. The facility's investigation revealed that Resident #3 NJ Exec Order 26.4b1 CHHA #9's NJ Exec Order 26.4b1 when the CHHA tried to NJ Exec Order 26.4b1 the resident with NJ Exec Order 26.4b1 their NJ Exec Order 26.4b1. Per the report, the CHHA felt that the resident was going to NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 the resident's NJ Exec Order 26.4b1 and told the resident NJ Exec Order 26.4b1. Per the facility's investigation, CHHA #9 should have NJ Exec Order 26.4b1 when she saw that the resident was NJ Exec Order 26.4b1 and should not have NJ Exec Order 26.4b1 the resident. The Reportable Event Record/Report revealed the facility NJ Exec Order 26.4b1 CHHA #9 pending investigation of the incident, then NJ Exec Order 26.4b1 the CHHA's employment.

A written statement from LPN #1, dated NJ Exec Order 26.4b1 revealed at approximately 7:20 AM, CHHA #9 reported that Resident #3 NJ Exec Order 26.4b1 as she attempted to NJ Exec Order 26.4b1 resident with their NJ Exec Order 26.4b1. According to LPN #1's statement, the staff member stated that she NJ Exec Order 26.4b1 the resident's NJ Exec Order 26.4b1 and stated, NJ Exec Order 26.4b1."

A written statement from CHHA #5, dated NJ Exec Order 26.4b1, revealed, as she walked down the hallway that morning, she witnessed CHHA #9 walk out of Resident #3's room, NJ Exec Order 26.4b1. Per the statement, CHHA #9 stated, "That NJ Exec Order 26.4b1. I'm NJ Exec Order 26.4b1, that NJ Exec Order 26.4b1, NJ Exec Order 26.4b1."

During an interview on 11/11/2025 at 2:24 PM, LPN #1 stated that on NJ Exec Order 26.4b1, she was Resident #3's assigned nurse. LPN #1 stated CHHA #9 attempted to NJ Exec Order 26.4b1 Resident #3 with

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NJ Exec Order 2 on their NJ Exec Orc and the resident attempted to NJ Ex CHHA #9. LPN #1 stated CHHA #9 reported to her that she NJ Exec Order 26.4b the resident's NJ Exec Or when the resident NJ Exec Order 26.4b1. LPN #1 stated she notified the Nurse Manager (NM) of the incident and assessed the resident, who did not appear to have NJ Exec Order 26.4b1 from the incident. LPN #1 stated CHHA #9 left the floor following the incident because she worked the 11:00 PM to 7:00 AM shift.

During an interview on 11/12/2025 at 2:05 PM, CHHA #5 stated that on NJ Exec Order 26.4b1 she was walking down the hallway when she saw CHHA #9 leaving Resident #3's room and NJ Exec Order 26.4b1 as she walked past her. CHHA #5 stated she did not see CHHA #9 say anything to the resident directly.

During a telephone interview on 11/13/2025 at 9:00 AM, CHHA #9 stated she worked with Resident #3 during the 11:00 PM to 7:00 AM shift and had limited interaction with the resident because the resident NJ Exec Order 26.4b1 during her shift. CHHA #9 stated that on NJ Exec Order 26.4b1 between 7:15 AM and 7:20 AM she answered Resident #3's call light. CHHA #9 stated Resident #3 asked her for NJ Exec Order 26.4b1 with NJ Exec Order 2 on a NJ Exec Orc which was unusual for the resident, as they NJ Exec Order 26.4b1 ADL care. CHHA #9 stated she asked Resident #3 why they needed NJ Exec C with NJ Exec Order 26.4b1, because she thought the resident NJ Exec Order 26.4b1. CHHA #9 stated Resident #3 NJ Exec Order 26.4b1 with the staff member and NJ Exec Order 26.4b1. CHHA #9 stated she left the resident's room and gave her pager to a co-worker, because she was coming off the 11:00 PM to 7:00 AM shift, and returned to Resident #3's room two to five minutes later to check on the resident. CHHA #9 stated that when

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she entered Resident #3's room, the resident attempted to NJ Exec Order 26.4b1. CHHA #9 stated she instinctively NJ Exec Order 26.4b1 the resident's NJ Exec Or and told the resident either, NJ Exec Order 26.4b1 or NJ Exec Order 26.4b1 CHHA #9 stated she left Resident #3's room, informed LPN #1 about the incident, and went home. CHHA #9 stated she did not think the incident would be considered NJ Exec Order 2 She stated that she NJ Exec Order 26.4b1 because she wore NJ Exec Order 26.4 and did not want to NJ Exec Order 26.4b1. CHHA #9 stated she was NJ Exec Order 26.4b1 following the incident, and the facility NJ Exec Order 26.4b1 her employment 48 hours later.

During an interview on 11/11/2025 at 9:38 AM, the NM stated she expected staff to NJ Exec Order 26 and NJ Exec Order 26.4b1 a resident if they became NJ Exec Orde during care and expected staff to stay within NJ Exec Order 26.4b1 of a resident if the resident became NJ Exec Order 26.4b1 The NM stated she would consider a staff member NJ Exec Order 26.4b1 a resident's NJ Exec Order 26.4b1, and she expected staff to notify the floor nurse of any incident involving a resident.

During an interview on 11/13/2025 at 1:14 PM, the Chief Operating Officer (COO) stated she expected staff to NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 if a resident became NJ Exec Order 26.4b1 during care. She stated that it was not acceptable to NJ Exec Or a resident by the NJ Exec Or or NJ Exec Orde the resident for displaying NJ Exec Order 26.4b1. The COO also stated that she expected staff to notify the nurse for assistance if a resident became NJ Exec Order 26.4b1 during care.

2. An "Admission Record" revealed the facility admitted Resident #4 on NJ Exec Order 26.4b1. According to the Admission Record, the resident had a medical history that included diagnoses of NJ Exec Order 26.4b1

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with NJ Exec Order 26.4b1 .

Resident #4's "Service Plan," included a focus area initiated NJ Exec Order 26.4b1 that indicated the resident NJ Exec Order 26.4b1 with activities of daily living (ADL) care due to NJ Exec Order 26.4b1 Interventions directed staff to NJ Ex Order 26.4(the resident if NJ Exec Order 26.4b1 was NJ Exec Order 26.4b1 (initiated NJ Exec Order 26.4b1 and for the resident's private aide to assist with care, NJ Exec Order 26.4b1, and take the resident to the NJ Exec Order 26.4b1 before leaving in the morning (initiated NJ Exec Order 26.4b1

Resident #4's "Progress Note" revealed an "Incident Note," with an effective date of NJ Exec Order 26.4b1 at 8:30 AM, created by Licensed Practical Nurse (LPN) #1. Per the note, the Nurse Manager (NM) notified the LPN that a staff member had reported incidents that had occurred with a private duty aide. Per the note, during the night, Resident #4 appeared to be NJ Exec Order 2 and NJ Exec Order 26 and the private duty aide commented, NJ Exec Order 26.4b1 " and pulled out a NJ Exec Order 26.4b1 from her purse. The note revealed the private duty aide NJ Exec Order 26.4b1, got an ice cream out of the resident's freezer, and administered the medication in the ice cream. The note revealed that the Certified Homemaker-Home Health Aide (CHHA) also reported that at the end of the shift, the private duty aide stated that she NJ Exec Order 26.4b1 " The Incident Note revealed LPN #1 assessed Resident #4 and the resident was ' NJ Exec Order 26.4b1 when approached. Per the note, Resident #4 did not have NJ Exec Order 26.4b1.

A "Reportable Event Record/Report," dated NJ Exec Order 26.4b1, revealed that on NJ Exec Order 26.4b1 at approximately 11:30 PM, CHHA #3 witnessed

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Private Care Giver (PCG) #14, a PCG hired by the resident's family, tell Resident #4, NJ Exec Order 26.4b1 [redacted] The CCHA reported that PCG #14 then removed a NJ Exec Order 26.4b1 from her purse, began crushing the tablet, and went to the refrigerator to mix the tablet in ice cream. Per the report, CHHA #3 left the room. The report further revealed that on NJ Exec Order 26.4b1 at approximately 6:45 AM, PCG #14 told CHHA #3 that Resident #4 had NJ Exec Order 26.4b1 twice during the night and that she NJ Exec Order 26.4b1 [redacted] The Reportable Event Record/Report revealed Resident #4 was assessed following the NJ Exec Order 26.4b1. The Reportable Event Record/Report also revealed that Resident #4's representative (RR) #17 NJ Exec Order 26.4b1 PCG #14's employment and the PCG was placed on a NJ Exec Order 26.4b1 for the facility. The report revealed that the facility determined that PCG #14's NJ Exec Order 26.4b was NJ Exec Order 26.4b1 and posed potential risk to the resident's safety and well-being.

During an interview on 11/12/2025 at 8:39 AM, CHHA #3 stated she worked the 11:00 PM to 7:00 AM shift on NJ Exec Order 26.4b1 through NJ Ex Order 26.4(b)(1) and Resident #4 was in her assignment. CHHA #3 stated Resident #4 had a private care giver who sat with the resident from 11:00 PM to 7:00 AM. CHHA #3 stated Resident #4 needed NJ Exec Order 26.4b1 care and NJ Exec Order 26.4b1 during the night. According to CCHA #3, at approximately 11:30 PM on NJ Exec Order 26.4b1, she stopped in Resident #4's room and was talking with PCG #14 when the resident NJ Exec Order 26.4b1 [redacted] Per CHHA #3, the PCG stated, "NJ Exec Order: [redacted]" Per CHHA #3, PCG #14 went to her

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purse and told the CHHA that she was going to give the resident a NJ Exec Order 26.4b1. CHHA #3 stated that PCG #14 NJ Exec Order 26.4b1 from her purse and got a strawberry vanilla ice cream from the resident's freezer. Per the CHHA, she left the room and did not witness the PCG give the resident the medication. CHHA #3 stated that she did not notify anyone of the incident because NJ Exec Order 26.4b1 ." CHHA #3 stated she conducted rounds every two hours during the 11:00 PM to 7:00 AM shift on NJ Exec Order 26.4b1, and both the resident and PCG #14 were NJ Exec Order 26.4b1 she went to the room. CHHA #3 stated that in the morning on NJ Exec Order 26.4b1 PCG #14 NJ Exec Order 26.4b1 Resident #4 to the common area for breakfast and told CHHA #3 that Resident #4 NJ Exec Order 26.4b1 that morning. CHHA #3 stated she asked PCG #14 why she did not ask for help when she was providing care to Resident #4, and PCG #14 told her that she NJ Exec Order 26.4b1 ." CHHA #3 stated she walked to her car at approximately 7:30 AM and called CHHA #6 to report the incident. CHHA #3 stated she was assigned to Resident #4 the following night on NJ Exec OrdeNJ Ex Order on the 11:00 PM shift and did not observe NJ Exec O to the resident.

During an interview on 11/12/2025 at 2:15 PM, CHHA #6 stated that on NJ Exec Order 26.4b1, CHHA #3 reported the NJ Exec Order 26.4b1 involving Resident #4 and PCG #14, and she notified the NM of the NJ Exec Order 26.4b1 as soon as she got off the phone with CHHA #3. Per CHHA #6, PCGs could not give medications to residents.

During an interview on 11/11/2025 at 2:43 PM, LPN #1 stated that on NJ Exec Order 26.4b1 she spoke with PCG #14 as the PCG was leaving the facility

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following the 11:00 PM to 7:00 AM shift. LPN #1 stated that PCG #14 told her that Resident #4 had NJ Exec Order 26.4b1 during the shift while she was trying to NJ Exec Order 26.4b1. LPN #1 stated she tried to get further details from PCG #14 and asked her why she did not ask for NJ Exec O with the resident. LPN #1 stated PCG #14 responded by saying, NJ Exec Order 26.4b1. LPN #1 stated that within an hour after her conversation with PCG #14, she received a call from the NM notifying her that PCG #14 may have NJ Exec Order 26.4b1 Resident #4. LPN #1 stated she assessed the resident and took their vital signs before notifying the resident's physician of the NJ Exec Order 26.4b1 LPN #1 stated that the resident appeared in NJ Exec Order 26.4b1 and had NJ Exec Order 26.4b of NJ Exec Order According to LPN #1, she expected the CHHA to report the incident when the PCG told the resident "NJ Exec Order 26.4b1 ."

During a telephone interview on 11/13/2025 at 9:33 AM, RR #17 stated they hired a private duty aide to NJ Ex with Resident #4 on a NJ Exec Order 26.4b1 while the resident NJ Exec Order 26.4b to the facility. RR #17 stated that as Resident #4 NJ Exec Order 26.4b to the facility, they reduced the private duty aide's time to the 11:00 PM to 7:00 AM shift because the resident NJ Exec Order 26.4b1 . RR #17 stated they had told PCG #14 to ask for facility staff's help if Resident #4 NJ Exec Order 26.4b1, RR #17 stated the NM called on NJ Exec Order 26.4b1 at approximately 8:30 AM and notified the RR of the NJ Exec Order 26.4b1. RR #17 stated they dismissed PCG #14 that same day and NJ Exec Order 26.4b1 .

During an interview on 11/11/2025 at 9:46 AM, the NM stated that the facility was unable to confirm whether PCG #14 gave Resident #4 a NJ Exec Order 26.4b1

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A 389	Continued From page 14 because it was not witnessed. Per the NM, PCGs were not authorized to administer medication. The NM stated staff had been trained to report incidents to the nurse when they occurred, and she expected staff to report incidents immediately. During an interview on 11/13/2025 at 1:36 PM, the Director of Nursing (DON) stated that CHHA #3 did not report the incidents that occurred on NJ Exec Order 26.4b1 at approximately 11:30 PM or the incident that occurred on NJ Exec Order 26.4b1 at approximately 6:45 AM until NJ Exec Order 26.4b1 at 8:15 AM. During an interview on 11/13/2025 at 1:43 PM, the Chief Operating Officer (COO) revealed that CHHA #3 should have reported the incident of NJ Exec Order 26.4b1 and attempted medication administration that occurred on NJ Exec Order 26.4b1 at 11:30 PM, right away.	A 389		
A 565	8:36-5.10(a)(3) General Requirements (a) The facility shall notify the Division of Health Facility Survey and Field Operations immediately by telephone at (609) 633-9034 (609) 392-2020 if after business hours, followed within 72 hours by written confirmation, of the following: 3. Any suspected cases of resident abuse or exploitation which have been reported to the State Long-Term Care Ombudsman.	A 565		

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A 565	Continued From page 15 This REQUIREMENT is not met as evidenced by: Complaint #NJ00163220 Based on record review, interview, and facility document and policy review, the facility failed to ensure a written confirmation was provided to the state survey agency (SSA) within 72 hours of an NJ Exec Order 26.4b1 for 1 (Resident #1) of 4 NJ Exec Order 26.4b1 reviewed. Findings included: An undated facility policy titled, "Abuse Prevention Program," revealed, "7. Investigate and report any allegations of abuse within timeframes as required by federal requirements." An "Admission Record" indicated the facility admitted Resident #1 on NJ Exec Order 26.4b1. According to the Admission Record, the resident had a medical history that included diagnoses of NJ Exec Order [redacted]. Resident #1's "Service Plan Report," included a focus area initiated NJ Exec Order 26.4b1, which revealed that the resident had activity of daily living needs related to NJ Exec Order 26.4b1 Interventions directed staff to assist the resident with NJ Exec Order 26.4b1 and provide NJ Exec Order 26.4b1 at times (initiated NJ Exec Order 26.4b1. A "Reportable Event Record/Report," dated NJ Exec Order 26.4b1, revealed that on NJ Exec Order 26.4b1 during the 3:00 PM to 11:00 PM shift, Home Health Aide (HHA) #19 was speaking with a co-worker, HHA #20. During the staff members' conversation,	A 565		

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A 565	Continued From page 16 Resident #1 NJ Exec Order 26.4b1 because the resident NJ Exec Order 26.4b1. Per the report, HHA #20 responded and told the resident to "NJ Exec Order 26.4b1" The report revealed HHA #19 reported the NJ Exec Order 26.4b1 of NJ Exec Order to the Nurse Manager (NM). A fax cover letter from the Chief Operating Officer (COO) and a time stamp on the Reportable Event Record/Report revealed the facility reported the NJ Exec Order 26.4b1 to the SSA on NJ Exec Order 26.4b1 five days after the incident occurred. During an interview on 11/11/2025 at 9:33 AM, the NM stated that she did not remember anything specific, only what was documented regarding the time that the NJ Exec Order 26.4b1 was reported to the SSA. During a follow-up interview on 11/11/2025 at 12:09 PM, the NM stated NJ Exec Order 26.4b1 of NJ Exec Order should be reported immediately but stated that there was no specific timeframe requirement to report. During an interview on11/11/2025 at 10:04 AM, the Chief Operating Officer (COO) stated they tried to report NJ Exec Order 26.4b1 of NJ Exec Order by phone to the SSA within two hours and had to submit a written report the next day. The COO stated she thought she submitted a written report for the NJ Exec Order 26.4b1 involving Resident #1 on NJ Exec Order 26.4b1 but stated she would have to look to confirm the date and time. During a follow-up interview on 11/11/2025 at 11:54 AM, the COO stated she could not find any other documentation related to the date and time the incident was reported to the SSA.	A 565		

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A 891	Continued From page 17	A 891		
A 891	8:36-10.5(a) Dining Services (a) The facility and personnel shall comply with the provisions of N.J.A.C. 8:24, Retail Food Establishments and Food and Beverage Vending Machines Chapter XII of the New Jersey Sanitary Code. This REQUIREMENT is not met as evidenced by: Based on observation, interview, facility policy review, and review of the New Jersey Administrative Code (N.J.A.C.) 8:24, "Sanitation in Retail Food Establishments and Food and Beverage Vending Machines," the facility failed to store eating utensils in a sanitary manner and failed to sanitize a thermometer between testing each food on the food preparation table. Findings included: 1. N.J.A.C. 8:24-4.11 revealed, "(e) Equipment, utensils, linens, and single-service and single-use articles protection requirements shall include the following: 2. Clean equipment and utensils shall be stored ii. Covered or inverted." An undated facility policy titled, "Flatware Washing Procedure," revealed, "6. Storage/Re-Use A. Place [flatware] into dispenser for use business end down, not touching the	A 891		

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A 891	Continued From page 18 eating part of the utensils with bare hands." During an observation of the facility kitchen (a satellite kitchen) on 11/20/2025 at 11:31 AM, an eight-compartment container was observed on the food preparation table with forks and spoons stored with the food contact surface facing up. A second eight-compartment container was observed underneath the food preparation table with additional forks and spoons stored with the food contact surface facing up. On 11/20/2025 at 11:31 AM, the Culinary Manager (CM) stated the utensils should be faced down. 2, N.J.A.C. 8:24-2.1 revealed, "(c) The person in charge shall ensure the following: 6. That employees are properly trained in food safety as it relates to their assigned duties." An undated facility policy titled, "Food Temperatures," revealed, "4. The thermometer must be sanitized between testing of each food item to avoid contaminating the food being tested. When monitoring only raw foods, or only cooked foods being held, it is acceptable, to wipe the stem of the thermometer with an alcohol swab between measurements." During an observation on 11/10/2025 at 11:40 AM, Culinary Supervisor (CS) #18 took temperatures of food items including tuna, fruit cocktail, butternut squash soup, baked beans, snapped peas, and quiche. After checking the temperature of each food item, the staff member rinsed the thermometer probe with water. CS #18 stated he was not aware of the policy related to cleaning and sanitizing the thermometer between foods.	A 891		

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A 891	Continued From page 19 During an interview on 11/13/2025 at 8:45 AM, the Culinary Manager (CM) stated staff should use a sanitizing wipe on the food thermometer probe between each food item. The CM stated they had just run out of wipes; however, there was a bucket of sanitizer available. During an interview on 11/13/2025 at 10:01 AM, the Nurse Manager (NM) stated she would expect the thermometer to be sanitized between each food, especially with them being Kosher. She stated she expected sanitary practices to be followed. During an interview on 11/13/2025 at 10:13 AM, the Chief Operating Officer (COO) stated staff should use sanitizing wipes between testing food items and confirmed that food utensils should be stored inverted.	A 891		
A1011	8:36-11.7(k) Pharmaceutical Services (k) Controlled dangerous substances shall be stored, and records shall be maintained, in accordance with the Controlled Dangerous Substances Acts, N.J.S.A. 24:21-1 et seq. and all other Federal and State laws and regulations concerning the procurement, storage, dispensation, administration, and disposition of same. This REQUIREMENT is not met as evidenced by: Complaint #NJ0080626 Based on interview, record review, and facility	A1011		

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policy review, the facility failed to maintain accurate records of controlled medications in 1 (Nurse's Station LG, second floor) of 4 medication carts.

Findings included:

An undated facility policy titled "Controlled Substances" revealed, "Controlled Substances shall be administered in a safe and timely manner and as prescribed." The policy directed facility staff to, "3. Complete documentation in the narcotic book prior to administering controlled substances to the resident. Check the count with each administration to ensure accuracy. Documentation of administration is completed after administering the medication." The policy revealed, "When breakage or wastage of all of a partial dose of a controlled substance not in its original sealed package and/or not administered to a patient occurs, the amount administered and the amount wasted shall be recorded by the licensed person who wasted the controlled substance and verified by the signature of another licensed person who observed the wastage and how it was wasted. Controlled substances shall be wasted in such a manner that such substances are rendered unusable." The policy for counting revealed, "1. All controlled substances, including medications in the refrigerator, must be counted at each shift change. Both the oncoming and outgoing nurse should look at the card and the narcotic book to ensure accuracy."

An "Admission Record" revealed the facility admitted Resident #6 on [redacted]. According to the Admission Record, the resident had a medical history that included diagnoses of [redacted]

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A1011	Continued From page 21 NJ Exec Order 26.4b1). Resident #6's NJ Exec Order 26.4b1 Medication Administration Record (MAR) revealed an order, dated NJ Exec Order 26.4b1 for NJ Exec Order 26.4b1 one tablet six times daily at 5:00 AM, 9:30 AM, 10:30 AM, 2:30 PM, 4:00 PM, and 5:00 PM related to diagnoses of NJ Exec Order 26.4b1 . A "Reportable Event Record/Report," dated NJ Exec Order 26.4b1, revealed that on NJ Exec Order 26.4b1 at 4:00 PM, there was a discrepancy in the NJ Exec Order 26.4b1 count. The Reportable Event Record/Report revealed that on NJ Exec Order 26.4b1 during the 3:00 PM to 11:00 PM shift change NJ Exec Order 26.4b1 count, Resident #6's had 13 tablets of NJ Exec Order 26.4b1 remaining in a package, and according to the NJ Exec Order 26.4b1 count documentation, the resident should have had 14 tablets remaining. The report revealed that it was possible that the NJ Exec Order 26.4b1 tablet was wasted due to a "puncture in the packaging." Resident #6's "Individual NJ Exec Order 26.4b1 Record" for NJ Exec Order 26.4b1 dated NJ Exec Order 26.4b1 to NJ Exec Order 26.4b1 revealed staff documented that the medication was administered to the resident on NJ Exec Order 26.4b1 at 2:30 PM by Licensed Practical Nurse (LPN) #2, on NJ Exec Order 26.4b1 at 4:00 PM by LPN #15, and on NJ Exec Order 26.4b1 at 5:00 PM by LPN #10. During an interview on 11/12/2025 at 4:45 PM, LPN #10 stated that during shift changes, the oncoming and off-going nurses counted the number of the NJ Exec Order 26.4b1 medications in the medication cart to verify the counts were accurate. LPN #10 stated the off-going nurse	A1011		

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normally had the [redacted] count book and would state the number of medications recorded on each of the individual [redacted] records, while the oncoming nurse would count the number of pills in each of the medication cards to verify the numbers. LPN #10 stated she found a discrepancy when counting the [redacted] one time but could not remember the date. After reviewing Resident #6's "Individual [redacted] Record" for [redacted], she verified her signature with LPN #15's signature on [redacted]. LPN #10 stated she reported the discrepancy to the Nurse Manager (NM).

During an interview on 11/11/2025 at 3:28 PM, LPN #2 stated that on [redacted] at 4:00 PM, LPN #10 noticed there was a [redacted] medication missing from one of the medication cards. LPN #2 stated she had counted the [redacted] on the medication cart that morning with LPN #15, who was supposed to visually count the number of pills on each card while LPN #2 called out the number on the [redacted] record. After the medication was discovered missing, LPN #2 stated that the NM held a meeting with the nursing staff, and during the meeting, LPN #15 admitted she did not count each individual pill on each card when she conducted the [redacted] count with LPN #2 on [redacted] LPN #2 stated that LPN #15 walked out of the meeting and did not return to the facility following the incident.

During an interview on 11/13/2025 at 10:31 AM, the NM stated that she was notified that a card of [redacted] medication was missing one pill on [redacted] at approximately 4:00 PM. The NM stated the discrepancy was found on [redacted] at 4:00 PM during the [redacted] count between LPN #15 and LPN #10. The NM stated she conducted a count of the [redacted] on the

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LIONS GATE	1100 LAUREL OAK ROAD VOORHEES, NJ 08043

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A1011	Continued From page 23 medication cart and verified the discrepancy. The NM stated a search was conducted through the medication cart for the missing pill, but the pill was not found. The NM stated she initiated an investigation and conducted interviews with the nursing staff involved. The NM stated the investigation was indeterminate as to what happened to the missing medication, but LPN #15 admitted that she did not lift the medication card during the count with LPN #2. The NM stated she conducted a meeting with the nursing staff following the incident to get further details on the incident, and LPN #15 could not explain what happened to the missing medication. The NM stated that when questioned, LPN #15 became NJ Exec Order 26.4b1 of the meeting. The NM stated she expected nursing staff to conduct a NJ Exec Order 26.4b1 count any time the keys to the medication cart were handed off, upon receipt of medications from the pharmacy, and before and after administration of a NJ Exec Order 26.4 medication to a resident. The NM stated she also expected nursing staff to verify that the number in the NJ Exec Order 26.4b1 record matched the number of pills on each medication card by visually inspecting the card. During an interview on 11/13/2025 at 11:17 AM, the Chief Operating Officer (COO) stated she also expected nursing staff to count the NJ Exec Order 26.4b1 medications by visually inspecting each medication card when conducting the shift-to-shift count.	A1011		
A1249	8:36-17.7 Housekeeping-Sanitation-Safety-Maintenance The building and grounds shall be well maintained at all times. The interior and exterior	A1249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04A003	A. BUILDING: _____ B. WING _____	C 11/13/2025

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
A1249	Continued From page 24 of the building shall be kept in good condition to ensure an attractive appearance, provide a pleasant atmosphere, and safeguard against deterioration. The building and grounds shall be kept free from fire hazards and other hazards to resident's health and safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure that all fire door assemblies throughout the facility were maintained, inspected, and tested annually as required by section 5.2.3 of "NFPA 80 Standard for Fire Doors and other Opening Protectives." The facility also failed to ensure that all exit discharge doors throughout the facility were constructed in a way to safely direct building occupants to the public way as required by section 1028.5 of the International Fire Code. This had the potential to affect 70 residents of the facility. Findings included: 1. The facility's "Inspection Testing Results" revealed "door control" was tested on 01/17/2025. There was no documented evidence that the inspection included the following areas that must be inspected during an annual fire door inspection: door surfaces, glazing and glass kit, door frame and hardware, hinges, door clearances, self-closing devices, latching hardware, coordinators, astragal and/or meeting	A1249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04A003	A. BUILDING: _____ B. WING _____	C 11/13/2025

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
A1249	Continued From page 25 edge of a pair of doors. The Inspection Testing Results did not satisfy the inspection requirements for fire doors as specified in "NFPA 80 Standard for Fire Doors and other Opening Protectives." During an interview on 11/12/2025 at 10:20 AM, the Director of Engineering and Maintenance (DEM) revealed it was the only report the facility had, and he was not aware that the inspection did not satisfy the regulatory requirements. 2. On 11/12/2025 at 12:10 PM the surveyor, accompanied by the Chief Operation Officer (COO) and Director of Engineering and Maintenance (DEM), observed that the exit discharge door from the first floor Activities Room directed occupants out of the building onto a six-foot-by-six-foot concrete pad at grade level directly outside the exit discharge door. This observed condition did not give building occupants the ability to travel to a public way or a designated gathering area as required by section 1028.5 of the International Fire Code. During an interview on 11/12/2025 at 12:10 PM, the DEM stated the facility did not conduct environmental surveillance rounds in the area where the Activities Room was located. During an interview on 11/12/2025 at 12:10 PM, the COO stated that the facility was unaware that the exit discharge was not in compliance with the fire code requirements.	A1249		

POC #3 received 1/8/26
Accepted 1/8/26

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Lions Gate Assisted Living #04A003
Plan of Correction form 11/13/15 survey
Submitted on 12/10/2025, 1/5/2026, 1/7/2026, 1/8/2026 via email: HFEL.POCAL@doh.nj.gov

A 310 Administration

1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice

   Residents #2 and #4 still reside in the Community with no further issues. Both residents [NJ Ex Order 26.4(b)(1)] by not having conducted a thorough investigation of [NJ Exec Order 26.4b1]

   In the situation with Resident #2, there was no documented evidence that interviews/statements from staff working during the time of the incident, the resident, or PCG#22. To ensure that this does not happen again, an investigation checklist was created on 12/29/2025 by the AL Administrator to ensure that the appropriate steps are included and documented in the investigation. The AL Administrator or AL Nurse Manager will be responsible for competing the checklist when an investigation is required.

   In the case with Resident #4, the PCG#14 was not interviewed by the facility nor was a statement collected regarding the event that was reported. In order to ensure that this does not happen again, an investigation checklist will be created to ensure the appropriate steps are taken during an investigation.

2. How the facility will identify other residents having the potential to be affected by the same deficient practice
   All residents who are involved with an investigation have the potential to be affected by the same deficient practice.

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

   In order to ensure that investigations are conducted thoroughly and documented, a checklist was created on 12/29/2025 by the AL Administrator. The checklist includes tasks that should be completed and documented when conducting investigations. The checklist will be completed by the AL Administrator or Assisted Living Nurse Manager.

4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic changes

   The Nurse Manager will review the Investigation Checklist during the monthly QAPI meeting for six months. Based upon the results of the Investigation Checklist, recommendations will be made if the review of the checklists need to determine if further monitoring is required.

5. Date of Completion: January 7, 2026 [redacted] approved 1/8/26

A 389 Resident Rights

Resident #3

1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice

   Resident #3 still residents at the Community with no further issues. Resident #3 and CHHA#9 had an [redacted] that resulted in the Resident #3 [redacted] of CHHA #9 while performing [redacted] As a result, CHHA #9 [redacted] the Resident #3's [redacted] and told [redacted] CHHA#9 should have [redacted] from the resident and get assistance from the floor nurse. CHHA #9 was immediately removed from the schedule on [redacted] and [redacted] pending investigation. Upon conclusion of the investigation, CHHA #9 was [redacted] from her position at Lions Gate.
   As a result of this incident, staff were in-serviced on December 10, 2024, by Assisted Living Nurse Manger regarding [redacted] and how to handle difficult residents. Staff were instructed that it is never acceptable to [redacted] on a resident.

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

   Since one of the CHHAs did not conduct herself in an appropriate manner, all residents living in Assisted Living have the potential to be affected by the deficient practice.

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

   Staff members were in-serviced on December 10, 2024 by the Assisted Living Nurse Manager regarding preventing resident abuse as well as how to handle combative residents. In addition, during weekly staff meetings, discussions occur about residents that are having a difficult time and how staff members can approach the resident/situation more effectively. New staff members are educated about preventing resident abuse and how to handle difficult residents upon hire.

Due to the recent survey findings, all staff will be re-educated on how to prevent resident abuse and how to handle difficult residents. This re-education occurred on December 9, 2025 by the Assisted Living Nurse Manager.

4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic changes.

   The Assisted Living Nurse Manager and/or Administrator will conduct weekly meetings with staff to address any potential resident issues that are identified by staff. At these meetings, staff will have the opportunity to receive support and guidance on how to handle situations that may arise.

   To monitor the continued effectiveness of the systemic changes, the Assisted Living Nurse manager will conduct weekly audits of resident concerns, interventions, and follow-up actions will be completed by the Assisted Living Nurse Manager weekly for four weeks and then monthly for six months. **Results of the monitoring** will be reviewed during monthly QAPI meetings to assess continued compliance and determine if additional corrective measures are needed. After the audits are completed, the QAPI committee will determine if further monitoring is needed.

[redacted] approved 1/8/26

Resident #4

1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice

   Resident #4 still resides at Lions Gate with no further issues. It is [redacted] at Resident #4 was given [redacted] by his/her private care giver on [redacted] In addition, the same private duty aide may have [redacted] the resident (on the morning of [redacted] without leaving any evidence. CHHA#3 reported the incident the morning of [redacted] The family was notified about the incident and was asked not to have the private care giver return to Lions Gate. The family agreed and informed the private care giver not to return.

   The resident was examined and evaluated on [redacted] at 17:34 pm by the physician for any side effects from the [redacted] and [redacted] due to [redacted] No [redacted] were observed.

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

   All residents have the potential to be affected by the same deficient practice from any caregiver that is employed by family members or by Lions Gate.

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

   CHHA#3 was in-serviced by the Assisted Living Nurse manager on November 3, 2025 regarding about recognizing potential abuse and/or neglect of residents and the importance of reporting suspicious events immediately to a supervisor.

   The Assisted Living Nurse Manager will conduct in-service training sessions for employees on recognizing potential signs of resident abuse and/or neglect on December 9, 2025. These sessions will also emphasize the critical importance of immediately reporting to a supervisor any event, concern, or observation that could be considered abuse or neglect.

4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic changes.

   The Assisted Living Nurse Manager and/or Administrator will hold weekly staff meetings to review and address any resident concerns identified by team members, including the identification of potential resident abuse and ensuring it is reported in a timely manner. These meetings will also provide staff with guidance and support on managing situations as they arise.

   To ensure the ongoing effectiveness of the systemic changes, the Assisted Living Nurse Manager will perform weekly audits of resident concerns, interventions, and follow-up actions for four weeks, followed by monthly audits for an additional six months. The results of these audits will be reviewed during the monthly QAPI meetings to evaluate continued compliance and determine whether further corrective actions are necessary. After the audit cycle is completed, the QAPI committee will decide if ongoing monitoring is required.

5. Date of Completion: December 17, 2025

[redacted] approved 1/8/26

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A 565 General Requirements

1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice

   Resident #1 no longer resides at Lions Gate. Although a reportable event was completed regarding a situation involving Resident #1, the resident was NJ Exec Order 26.4b1 by the deficient practice. Administration was unable to ensure that written confirmation was provided to the state survey within the required 72 hours. As a result, the Administrator will develop a Reportable Event Checklist outlining all required reporting tasks and associated timeframes to ensure compliance in the future.

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

   All residents who are involved in a reportable event have the potential to be affected by the same deficient practice if administration fails to ensure that written communication was provided to the state survey agency within 72 hours of an abuse allegation.

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

   To ensure that the same deficient practice will not recur, the Assisted Living Administrator created a Reportable Event Check List on 12/30/2025. This check list will include all the steps that need to be completed with time frames to ensure that the required steps are followed.

4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic changes

   When reportable events occur in the future, the checklist will be used by the Assisted Living Administrator or Assisted Living Nurse Manager. The completion of the checklist will be reviewed

when the reportable event is submitted by the Administrator or Nurse Manager for accuracy. The Nurse Manager will review the Reportable Event checklists at the monthly QAPI meetings for 6 months. Based upon the findings, recommendations will be made regarding further monitoring of the checklist.

5. Completion Date: January 7, 2026 [redacted] approved 1/8/26

A 891 Dining Services

Utensils

1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice

   While no resident (s) were found to have been affected by the deficient practice, all residents have the potential to be affected by the flatware being stored improperly. Flatware is to be stored inverted—into holder with the business end down. Dining staff received an in-service on November 13th by the Assistant Dining Director regarding the proper way flatware is to be stored.

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

   All residents who eat in the dining room have the potential to be affected by the deficient practice since the flatware was not stored properly.

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

   Staff were in-serviced on November 13th, 2025 regarding the proper storage of flatware. When new staff members are hired, the Assistant Director of Dining will provide education on how to properly store flatware. In addition, proper storage of flatware will be reviewed at monthly meetings for six months.

4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic changes.

The Assistant Director of Dining will conduct audits weekly for four weeks, then bi-weekly for four weeks, then monthly for 6 months. The Assistant Director will report all findings in the monthly QAPI meetings. At the conclusion of the audits it will be determined if the audits will need to continue based upon the findings.

Thermometer

1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice

   Since the thermometer was not cleaned with an alcohol swab between measurements and instead cleaned with water, all residents who ate lunch that day were affected by the deficient practice. Since wipes were not available on November 10, 2025, the staff member should have cleaned the thermometer in the bucket of sanitizer. As a result of this deficient practice, dietary staff members were re-educated about the proper use way(s) to sanitize thermometers on November 13, 2025.

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

   All residents who eat in the Community have the potential to be affected by the deficient practice.

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

   Wipes were made available to the staff on November 13, 2025. Moving forward, the Assistant Director of Dining will ensure that wipes are available. If the Community is out of the wipes, staff have been educated that the proper way to clean the thermometers is with a bucket of sanitizer, not with water. All new staff will also be educated on the proper way to clean thermometers as part of the orientation. In addition, proper cleaning of thermometers will be reviewed at monthly meetings for six months.

4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic changes.

   The Assistant Director of Dining will conduct audits regarding the proper handling of thermometers. The audits will take place weekly for 4 weeks, bi-weekly for 4 weeks and then monthly for 6 months.

All results will be reviewed in the monthly QAPI meetings. Depending upon the results, recommendations will be made about continuing the audits.

5. Date of Completion: November 14, 2025 [redacted] approved 1/8/26

A 1011 Pharmaceutical Services

1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice

   Resident #6 was affected by one missing tablet of [redacted] The tablet was replaced as soon as it was identified that the count was off by one tablet. All nursing staff was immediately in-services regarding the proper way to count narcotics as well as reporting any concerns to the Nurse Manager.
2. How the facility will identify other residents having the potential to be affected by the same deficient practice

   All Assisted Living residents who have their medications administered to them by the Community have the chance to be affected by the deficient practice.

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

   Nursing staff was immediately in-serviced on May 29, 2024 by the Assisted Living Nurse Manager on the proper way to conduct a medication count. In addition to the re-education that was provided, all new nursing staff that dispenses medications will receive training on how to properly conduct and participate in a medication count as part of orientation.

   Due to the findings of the recent survey, nursing staff was re-educated on 12/19/2025 regarding the proper way to conduct a medication count by the Assisted Living Nurse Manager.

4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic changes.

   The Assisted Living Nurse manager will conduct random audits of the NARC counts 1x a week for 4 weeks, then bi-weekly for 4 weeks, then monthly for 6 months. Results from the findings will be

reported in the monthly QAPI meetings. Recommendations for continued monitoring will depend upon the results of the audit.

5. Date of Completion: December 19th, 2025 [redacted] approved 1/8/26

A1249 Housekeeping-Sanitation-Safety-Maintenance
Inspection Testing Results

1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice

   No residents were found to been affected by the Inspection Testing Results not satisfying the inspection requirements for the fire doors as specified in the "NFPA 80 Standard for Fire Doors and other Openings protectives."

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

   All residents who live in the Assisted Living have the potential to be affected by the Inspection Testing Results not satisfying the inspection requirements for the fire doors as specified in the "NFPA 80 Standard for Fire Doors and other Openings protectives."

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

   Because the Fire Inspection report inaccurately identified "Fire Door Control Inspections" instead of "Fire Door Inspections" on the annual report, Lions Gate's Director of Facilities met with Everon, the Fire Inspection Company, on November 20, 2025, and requested that the reports be corrected. The most recent annual Fire Door inspection was conducted on January 17, 2025, and all doors passed inspection. As of December 2, 2025, the report has been updated to accurately reflect Fire Door Inspections.

4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic changes.

The Director of Facilities will be responsible for monitoring the annual Fire Door Testing as well as appropriate language/description used on the annual testing report from Everon. If there should be any discrepancies, the Director of Facilities will work directly Everon. The Director of Facilities will share this annual report with the QAPI Committee on a yearly basis for two years to ensure the report meets the NFPA 80 Standard for Fire Doors and other openings.

Sidewalk

1. How the corrective action 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 exit discharge from the first-floor activities room door leading onto a six-foot by six-foot concrete pad at grade level vs. the exit providing the availability to travel to a public walkway or a designated gathering area. The exit has not changed since the Community opened in 2007.

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

   All residents living in Assisted Living have the potential to be affected by the deficient practice since this is a means of egress from the Community.

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

   The Director of Facilities contacted NJ Exec Order 26.4b1 to install a walkway from the Activities Rear Entrance to the common sidewalk. The installation of the sidewalk will take place on December 22, 2025.

4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic changes.

   Director of Facilities will be adding this new walkway to the monthly Preventative Maintenance Grounds inspections check list. This area will continue to be monitored monthly upon installation. Finding from the monthly Preventative Maintenance Grounds inspections will be shared at the QAPI

meetings for six months. At that time, recommendations will be made based upon the findings from the inspections.

5. Date of Completion: December 22, 2025

[redacted] approved 1/8/26

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
04A003 Y1	A. Building B. Wing Y2	1/8/2026 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 A0310	Correction	ID Prefix A0389	Correction	ID Prefix A0565	Correction
Reg. # 8:36-3.4(a)(1)	Completed	Reg. # 8:36-4.1(a)(16)	Completed	Reg. # 8:36-5.10(a)(3)	Completed
LSC	01/07/2026	LSC	12/12/2025	LSC	01/07/2026
ID Prefix A1011	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:36-11.7(k)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	12/19/2025	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	
11/13/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
04A003 Y1	A. Building B. Wing Y2	1/8/2026 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 A0389	Correction	ID Prefix A0891	Correction	ID Prefix A1011	Correction
Reg. # 8:36-4.1(a)(16)	Completed	Reg. # 8:36-10.5(a)	Completed	Reg. # 8:36-11.7(k)	Completed
LSC	12/12/2025	LSC	11/14/2025	LSC	12/19/2025
ID Prefix A1249	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:36-17.7	Completed	Reg. #	Completed	Reg. #	Completed
LSC	12/22/2025	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	
11/13/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO