

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

PRINTED: 03/06/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315499	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/17/2024
NAME OF PROVIDER OR SUPPLIER LIONS GATE			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
F 000	INITIAL COMMENTS Complaint #: NJ00176485 Census: 102 The facility is in compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities based on this complaint survey.	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

09/26/2024

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

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 04002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 09/17/2024
NAME OF PROVIDER OR SUPPLIER LIONS GATE		STREET ADDRESS, CITY, STATE, ZIP CODE 1100 LAUREL OAK ROAD VOORHEES, NJ 08043		
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S 000	Initial Comments Complaint #: NJ00176485 Census: 102 THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on review of pertinent facility documentation, it was determined that the facility failed to ensure staffing ratios were met to maintain the required minimum staff-to-resident ratios as mandated by the state of New Jersey for 1 of 14 evening shifts. The deficient practice was evidenced by the following: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified as N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio (s) were	S 560	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 deficient practice. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents had the potential to be affected by the deficient practice. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur: a)The Administrator, DON, HR Director and facility Recruiter will conduct bi-weekly	9/26/24

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New Jersey Department of Health

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S 560	Continued From page 1 effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer of all staff members shall be CNAs and each direct staff member shall be signed into work as a certified nurse aide and shall perform nurse aide duties: and one direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. The surveyor requested staffing for the weeks of 07/02/2023 to 07/15/2023, the facility was deficient in CNAs to total staff on 1 of 14 evening shifts as follows: -07/09/23 had 10 CNAs for 86 residents on the day shift, required at least 11 CNAs. 2. For the 2 weeks of Complaint staffing from 08/11/2024 to 08/24/2024, there were no deficient practices identified for staffing as submitted. 3. For the 2 weeks of staffing prior to survey from 09/01/2024 to 09/14/2024, the facility was deficient in CNA staffing for residents on 1 of 14 day shifts as follows: -09/08/24 had 12 CNAs for 103 residents on the day shift, required at least 13 CNAs.	S 560	meetings to discuss open positions and recruitment efforts. b)The community will continue with recruitment efforts to obtain addition staff. Recruitment efforts include but are not limited to: employee referral bonus, job fairs, social media job postings, sign on bonus, job postings on our website and Indeed. c)The community will continue to utilize agency staff for open shifts that need coverage. d)The community will continue to offer bonus pay and/or elevated pay such as time and a half and/or double time. We will also continue with shift differentials and weekend pay. e)When necessary, to meet the staffing nursing assistant to resident ratio, the community will offer incentives including monetary bonuses to nurses to fill the open nursing assistant positions. f)Prior to the beginning of a shift, if the staffing coordinator and/or nursing supervisor identifies a shortage of nursing assistants they will contact the Administrator, DON and ADON to support recruitment efforts for the shift. 4.How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: a)The staffing coordinator will audit the staffing ratios daily and report shift ratios to the Administrator and DON. b)The staffing coordinator will report the findings of the daily shift ratios at the monthly QAPI meeting X's 3 months. c) Results of the bi-weekly Staffing	

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S 560	Continued From page 2	S 560	Meetings will be reported by the HR Director at the monthly QAPI meeting X's 3 months.		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 04002	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 9/27/2024
NAME OF FACILITY LIONS GATE	STREET ADDRESS, CITY, STATE, ZIP CODE 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 S0560	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	09/26/2024	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
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 9/17/2024		☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			