STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315499	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIONS GATE	1100 LAUREL OAK ROAD , VOORHEES, New Jersey, 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
F0000	INITIAL COMMENTS Complaint #: NJ147082 and NJ146321 Census: 86 Sample Size: 11 The facility is not in compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities based on this complaint survey	F0000		
F0689 SS = G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Complaint Intake NJ146321 Based on interviews, record reviews, and facility policy and [NJ Exec Order] contract review, the facility failed to ensure the resident's environment remains as free of accident hazards as is possible, and that each resident received adequate supervision and [NJ Ex Order 26.4(b)(1)] to prevent accidents or injury for one resident (Resident #1) out of four residents reviewed for [NJ Ex Or]. Specifically, the facility failed to ensure that Resident #1 who was identified by the facility as a [NJ Ex Order 2] had his/her [NJ Ex] intervention which included to have bed [NJ Ex Order 26.4(b)(1)] and [NJ Ex Order 26.] in place	F0689	1. The corrective action for the residents affected by the deficient practice will be accomplished as follows: The resident was sent to the hospital immediately, and is [NJ Ex Order 26.4(b)(1)] the facility. Rounds were made by facility staff to ensure that all other residents were safe, with equipment in place. The [NJ Exec Order] aide in question was inserviced immediately at the facility, and was ultimately removed from her position at the [NJ Exec Order 2]. 2. Identification of other residents who could be affected by the deficient practice: Any resident care planned for fall precautions and the use of safety equipment, including floor mats and low bed, could have been affected by the deficient practice. 3. Measures or systemic changes to ensure that the deficiencies will not recur. Facility Charge Nurses were inserviced 6/28/21 – 7/4/21 on 1. ensuring that they meet with all hospice staff prior to beginning care to review the care plan, including fall precautions such as fall mats and low bed position 2. to instruct hospice staff to check in	10/08/2021

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 reverse for further 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315499	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/26/2021

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F0689 SS = G	Continued from page 1 whenever the resident was in bed and was in place before nursing staff exited the resident's room. It was determined that the facility's failed practice resulted in a NJ Ex Order 26.4(b)(1) (NJ Ex Order 26.4(b)(1) for Resident #1. Findings included: 1. Resident #1 was initially admitted on NJ Ex Order 26.4(b)(1) and readmitted on NJ Ex Order 26.4(b)(1) with diagnoses including NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1) , and NJ Ex Order 26.4(. The NJ Ex Order 26.4(b)(1) quarterly Minimum Data Set (MDS) revealed the resident had NJ Ex Order 26.4(b)(1) . The resident was NJ Ex Order 26.4(b)(1) on staff for all activities of daily living (ADLs). The resident required NJ Ex Order 26.4(b)(1) with NJ Ex Order 26.4(The facility submitted an AAS-45 (Facility Reportable Event) report to the New Jersey Department of Health on NJ Ex Order 26.4(b)(1) . The report indicated on NJ Ex Order 26.4(b)(1) , after a NJ Exec Order 2 aide provided care to Resident #1, the aide asked the nurse to get the resident out of bed. The NJ Exec Order 2 aide was not transferring residents due to the aide's NJ Ex Order 26.4(b)(1 The NJ Exec Order 2 aide proceeded to the next resident's care. When the nurse arrived to the resident ' s room, the resident was discovered on the floor. Resident #1 had NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b and a NJ Ex Order 26.4(b)(1 The resident was transferred to the hospital and diagnoses with a NJ Ex Order 26.4(b)(1) (NJ Ex Order 26.4(b)(1)). The report indicated NJ Ex Order 26.4 were not in place at the time of NJ Ex Order 2 . The facility's incident report dated NJ Ex Order 26.4(b)(1 indicated under the predisposing situation factor that contributed to Resident #1's NJ Ex as, 'NJ Ex Order 26.4(b)(1) with hands on care." The report noted under the other information portion of the report that Resident #1 was noted to be NJ Ex Order 26.4(b)(1) and at times could become NJ Ex Order 26.4 with care. It indicated the resident's NJ Ex was NJ Exec Order 26.4b1 It was further reported that Resident #1 was NJ Ex Order 26.4(b)(1) the floor in his/her bedroom. The resident was reported to have been NJ Ex Order 26.4 the floor with NJ Ex Order 26.4(b)(1) . The facility identified that NJ Exec Order 2 Aide (HA)#1 who was the last to provide care to the resident had NJ Ex Order the resident's bed and removed the NJ Ex Order 26.4 which was in place for the resident's NJ Ex while rendering care and	F0689	Continued from page 1 at the end of care to report any abnormalities 3. to review that the hospice staff is to stay with the resident and use the call bell to request staff assistance rather than leave the bedside 4. if hospice staff reports/appears unable to complete their duties, to have them report to the Nursing Supervisors to determine the course of action. In addition, the hospice company has adopted an electronic plan of care app which includes all DME and other interventions needed for each patient, which accompanies all hospice personnel caring for any facility residents. 4. Monitoring the continued effectiveness of the systemic change. The Director of Nursing or Unit Manager will perform weekly audits of hospice aides to ensure they are following the care plan for resident safety (including use of floor mats, low bed, or other interventions), and that the nurse has met with the hospice aide prior to care. The facility care plan will be checked against the Hospice care plan to ensure consistency. The results of these audits will be recorded by the DON or Unit Manager, and reported at QAPI committee monthly for 3 months.	

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F0689 SS = G	Continued from page 2 failed to return the resident's NJ Ex O back to the NJ Ex Order and likewise failed to replace the resident's NJ Ex Order 2 before she exited the resident's room to get the facility's staff's assistant with NJ Ex Order 26.4(b)(1) the resident from bed to NJ Ex Order 26.4(b)(1) per NJ Exec Order 1 care plan. It was noted that Resident #1 who was only oriented to NJ Ex O attempted to NJ Ex Order 26.4(b)(1) with the bed NJ Ex Order and without the NJ Ex Order 2 in placed NJ Ex Order 26 in the process. The report indicated that Resident #1 was transported to the hospital at 9:40 AM and returned to the facility at 2 PM with diagnosis of NJ Ex Order 26.4(b)(1). The report concluded that Resident #1's care plan was updated to reflect that, "After providing care to resident, if staying in bed, NJ Ex Order 26.4(b back to NJ Ex Order 26.4(b)(1) and replace NJ Ex Order 26.4(b)(1) and NJ Exec Order 3 staff will stay with resident until staff is available to assist with NJ Ex Order 26.4 Resident #1's care plan related to NJ Ex O indicated under the focus portion of the care plan that the resident was a NJ Exec Order 25 for NJ Ex O related to NJ Ex Order 26.4(b) NJ Ex O and NJ Ex Order 26.4(b)(1). The intervention portion of the plan indicated that after providing care to the resident, if the resident was staying in bed, staff should NJ Ex Ord the bed back to NJ Ex Order 26.4(b)(1) and replace NJ Ex Order 26.4(b)(1). It indicated that Resident #1 had had NJ Ex Order 26.4(b)(1) to the NJ Ex Order 26.4 on NJ Ex Order 26.4(b)(1) and an NJ Ex Order 26.4(b)(1) on NJ Ex Order 26.4(b)(1). Interviews with the facility's U.S. FOIA (b) (6) and the U.S. FOIA (b) (6) of NJ Exec Order 1 on NJ Ex Order 26.4(b)(1) at 9:56 AM and on NJ Ex Order 26.4(b)(1) at 10:15 AM, respectively, revealed the NJ Exec Order 1 care plan related to Resident #1's NJ E mirrored that of the facility. The U.S. FOIA also clarified that the NJ Exec Order 1 record was not kept as part of Resident #1's medical record at the facility. The surveyor requested a copy of NJ Exec Order 1 care plan for Resident #1. The U.S. FOIA said she would see if she could get it but did not get back to the surveyor on this. The progress note on NJ Ex Order 26.4(b)(1) at 10:00 AM by Licensed Practical Nurse (LPN) #1 revealed Certified Nurse Aide (CNA) #1 made LPN #1 aware that Resident #1 had been NJ Ex Order 26.4(b)(1) in the resident's room. The record indicated the resident was seen NJ Ex Order 26.4(b)(1) in a NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1). Resident #1 was noted to be NJ Ex Order 26.4(and NJ Ex Order 26.4(b)(1) at the time. Resident #1's vital signs (VS) were taken, and they recorded the following: NJ Ex Ord NJ Ex Order 26.4(b)(1); NJ Ex Order 26.4(b)(1); and NJ Ex Order 26.4(b)(1) The	F0689		

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F0689 SS = G	Continued from page 3 assessment revealed Resident #1 had NJ Ex Order 26.4(b)(1)) in NJ Ex Order 26.4(b)(1) and that Resident #1 NJ Ex Order 26.4(b)(1) to the NJ Ex Order 26.4(b)(1) the resident's NJ Ex Order 26.4(b) with NJ Ex Order present. The resident was observed to have NJ Ex Order 26.4(b)(1) . The facility received orders to send the resident to the hospital. A review of the NJ Ex Order 26.4(b)(1) hospital record revealed a NJ Ex Order 26.4(b)(1) of Resident #1's NJ Ex Ord indicated that Resident #1 NJ Ex Order 26.4(b) an NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1)). In the progress note of NJ Ex Order 26.4(b)(1) at 12:15 PM, LPN #1 indicated the facility received a call from the emergency department (ED) doctor at about 11:30 AM that Resident #1 was being sent back to the facility with a diagnosis of NJ Ex Order 26.4(b)(1) . The note indicated that NJ Exec Order services were to be continued with the resident. The note indicated that the resident's status was reported by the ED doctor to NJ Ex Order 26.4(b)(1) with the recommendation for the resident to return to the facility and to continue NJ Exec Order care. The medical record revealed Resident #1 returned to the facility on NJ Ex Order 26.4(b)(1) at 2:00 PM via Emergency Medical Transport (EMT). Resident #1 was NJ Ex Order 26.4(b)(1) to NJ Ex Order upon return to the facility. On NJ Ex Order 26.4(b)(1) at 7:00 AM, the record indicated that Resident #1 was NJ Ex Order 26.4(b)(1) or NJ Ex Order 26.4(b)(1) A review of Resident #1's NJ Ex Order 26.4(b)(1) revealed the immediate NJ Ex Order 26.4(b)(1) was ruled as NJ Ex Order 26.4(b)(1) The interval between NJ Ex Orde and NJ Ex Orde was indicated as NJ Ex Order 26.4 On 08/26/2021 at 10:43 AM, CNA #2 was interviewed and recalled Resident #1 had NJ Ex Order 26.4(and was NJ Ex Order on staff for all care. CNA #2 said Resident #1 NJ Exec Order 26.4b1 in bed, so the resident's bed always had to be NJ Ex Order 26.4(b)(1) , and the NJ Ex Ord always had to be in place. She said she was not present on the day of the incident with the resident. She said she was in-serviced after Resident #1's NJ Ex Orde and knew to never leave a resident's bed NJ Ex Order 26.4 with the resident in bed when she left the room. On 08/26/2021 at 10:48 AM, LPN #1 said Resident #1 was	F0689		

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F0689 SS = G	Continued from page 4 NJ Ex Order 26.4(b) with NJ Ex Order 26.4(b) She said the resident had no NJ Ex Order 26.4(b) and was able to NJ Exec Order 26.4b1 at times. She said Resident #1 was a NJ Ex Order 2 and was NJ Ex Order [redacted] on staff for care. She said she was in-serviced after the incident and a resident was never to be left NJ Exec O while in bed without putting the bed NJ Ex Order 26.4(b)(1) and the NJ Ex Order 26.4 in place if ordered/needed. She said that on the day of the incident, she (LPN #1) did her rounds in the morning, went into Resident #1's room and observed the resident was in bed with the bed NJ Ex Order 26.4(b)(1) and a NJ Ex Order 26.4 [redacted] the bed. She said that at approximately 8:55 AM, CNA #1 came to her and informed her that Resident #1 was NJ Ex Order 26.4(b)(1). She said when she went into Resident #1's room, she found the resident NJ Ex Order 26.4(b)(1) on the NJ Ex Order 26.4(b)(1) [redacted]. She said Resident #1 was NJ Ex Order 26.4 from the NJ Ex Ord The LPN said the bed was not at NJ Ex Order 26.4(b)(1) or NJ Ex Order 26.4(b)(1). She approximated that the NJ Ex Order 26 of the NJ Ex Order 26.4 was abou NJ Ex Order 26.4(b)(1) when she entered Resident #1's room. She stated neither of the NJ Ex Order 26.4(b)(1) were on the floor beside the bed at the time of the observation. The facility got an order to transfer the resident to the hospital for evaluation. LPN #1 said that Resident #1 was sent back to the facility after a short stay at the ED with the diagnosis of NJ Ex Order 26.4(b)(1) [redacted]. On 08/26/2021 at 11:27, NJ Exec Order 2 Aide (HA) #2 was interviewed. She said the first time working at the facility was back in NJ Ex Order 26.4(b)(1). She said she shadowed another NJ Exec Order [redacted] aide for four days then started working by herself. She said she had been a home health aide for approximately NJ Exec Order 26 prior to joining [NJ Exec Order 26 name omitted]. She said she took some computer-based training which included safe resident handling, transfers, how to give proper bed baths, emergency related trainings, etc. She said she did not take any training or competency tests at the facility related to safe resident NJ Ex Order 26.4 and NJ Ex Order 26.4 since she started working at the facility. She clarified that although she was working at the facility when the incident with Resident #1 occurred, she had not received any training following the incident. She said that when she needed help with NJ Ex Order 26.4(b)(1) a resident, she walked out in the hallway to get help. On 08/26/2021 at 12:15 PM, HA #1 (the NJ Exec Order [redacted] aide alleged to have left Resident #1 NJ Exec O when the NJ Ex Order 26.4(b)(1) [redacted]) was interviewed via telephone. She was no longer employed by the NJ Exec Order [redacted] company. She acknowledged she was the aide who provided care to	F0689		

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F0689 SS = G	Continued from page 5 Resident #1 before the resident was NJ Ex Order 26.4(b)(1). HA #1 stated that Resident #1 was NJ Ex Order 26.4(b)(1) on staff for care which included NJ Ex Order 26.4(b)(1). She said Resident #1 was NJ Ex Order 26.4(b)(1) in bed, so she required help with NJ Ex Order 26.4(b)(1) the resident. HA #1 explained the procedure she followed when she cared for Resident #1. She said she took the NJ Ex Order 26.4 off the floor in the resident's room as they posed a NJ Ex Order 2 for staff during care. She recalled she NJ Ex Order 26 and NJ Ex Order 26.4 the resident. HA #1 said Resident #1 was asleep throughout the time she cared for the resident. She said that due to being NJ Ex Order 26.4(b)(1) at the time, she relied on the facility staff to NJ Ex Order 26 Resident #1 to the resident's NJ Ex Order 26.4(b)(1), as that was the final component of NJ Exec Order 1 care with the resident. She said she left the resident's room with the resident's bed NJ Ex Order 26.4(b)(1). However, she acknowledged that she did not replace the NJ Ex Order 26.4. HA #1 said CNA #1 was within viewing distance from Resident #1's room when she (HA #1) stepped out to inform her (CNA #1) that she (HA #1) was finished providing for Resident #1 and the resident was ready to be NJ Exec Order 26.4b1 HA #1 said that CNA #1 immediately left in the direction of Resident #1's room. HA #1 said although Resident #1 was a NJ Ex Order 26.4(b)(1), she stated that CNA #1 approached Resident #1's room NJ Exec Or HA #1 stated that she was approximately five minutes into caring for another resident when CNA #1 informed her that Resident #1 was NJ Ex Order 26.4(b)(1). On 08/26/2021 at 1:21 PM, CNA #1 (agency CNA) was interviewed via telephone. She said she recalled the incident with Resident #1. She said HA #1 was finished providing care to the resident and had approached her to state that she (HA #1) needed Resident #1 to be NJ Ex Order 26.4(b)(to the NJ Ex Order 26.4(b. CNA #1 said that she immediately went in Resident #1's room to NJ Ex Order 26 the resident. CNA #1 acknowledged that she went in the resident's room without calling for other staff assistance and with the intent to NJ Ex Order 26 the resident NJ Exec Or She acknowledged that she knew the resident needed NJ Ex Order 26.4(b)(1) with NJ Ex Order 26. She said when she entered the room, the resident was NJ Ex Order with NJ Ex Order 26.4(b)(1). CNA #1 said the resident did not NJ E due to her attempt to NJ Ex Order 26 the resident by herself. On 08/26/2021 at 3:27 PM, CNA #3 said that when NJ Exec Order 2 aides arrived at the facility, they informed her that they would be needing her help with a resident's care at some point. She said NJ Exec Order 1 aides typically needed help with NJ Ex Order 26.4(b)(1) residents. She said when it was	F0689		

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F0689 SS = G	Continued from page 6 time to help the [NJ Exec Order] aide, the aide sometimes came to find her, or she checked in with the aide to know if her help was needed. On 08/26/2021 at 3:42 PM, CNA #4 said that when [NJ Exec Order] aides arrived at the facility, they asked about care needs of the residents they were assigned and clarified if there was any noted event with the resident. He said that [NJ Exec Order] CNAs had access to the care plans of the residents, just as the facility staff did. He concluded that [NJ Exec Order] aides came to the nursing station to request help, or they sometimes approached him in the hallway. On 08/26/2021 at 4:25 PM, a follow-up interview was conducted with the [U.S. FOIA] and the [U.S. FOIA (b) (6)]) present. The [U.S. FOIA] said that the facility's investigation determined the cause of Resident #1's [NJ Ex Order 26.4(b)] was from HA #1 leaving the room to get assistance instead of using the call bell, not making sure the resident's bed was in [NJ Ex Order 26.4(b)] and not putting the [NJ Ex Order 26.4(b)] back beside the bed. The [U.S. FOIA] acknowledged that the facility did not probe into CNA #1's intent to [NJ Ex Order 26] Resident #1 [NJ Ex Order] The [U.S. FOIA] said the facility was not responsible for training agency or contract staff. She said the contractual agreement the facility had with [NJ Exec Order] and agency staff was that they trained their staff before the staff were sent to work at the facility. A review of the [NJ Exec Order 26] Nursing Facility Services Agreement (The [NJ Exec Order] responsibility portion of the agreement) did not specifically delineate the type of training the facility wanted the [NJ Exec Order] staff to have. The [U.S. FOIA] provided copies of the in-services the facility did with nursing staff as well as the one provided by the [NJ Exec Order] company. The [U.S. FOIA] and the [U.S. FOIA] reviewed the [NJ Exec Order] training with the surveyor and were unable to provide additional documentation showing the facility ensured [NJ Exec Order 2] agency providers had trained their staff on the identified causes that contributed to Resident #1's [NJ Ex] The [U.S. FOIA] and the [U.S. FOIA] acknowledged that the facility was responsible for resident care whether it was from facility staff or outside provider's staff to ensure resident safety. Attempts made to interview the facility's [U.S. FOIA (b) (] and Resident #1's attending physician were unsuccessful due to not returning the surveyor's call. The facility's fall policy provided by the NHA on	F0689		

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F0689 SS = G	Continued from page 7 08/26/2021 at 12:16 PM read in part, "Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling ..." The fall-risk factors portion of the policy listed incorrect bed height or width as environmental factors which contributed to the risk of falls. The policy also listed delirium and other cognitive impairment as resident conditions that may contribute to the risk of falls. New Jersey Administrative Code § 8:39-27.1(a)	F0689		

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	10/12/2021 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 F0689 Reg. # 483.25(d)(1)(2) LSC	Correction Completed 10/08/2021	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	
8/26/2021	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO