STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315499	A. BUILDING _____ B. WING _____	02/09/2023

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

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F 000	INITIAL COMMENTS STANDARD SURVEY: Recertification CENSUS: 99 SAMPLE: 20 The facility was not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and interviews, the facility failed to ensure the Minimum Data Set (MDS) assessment accurately reflected a resident's dental status for 1 (Resident #161) of 1 sampled resident reviewed for dental services. A review of Resident #161's "Admission Record" revealed the resident had diagnoses that included Ex Order 26.4B1 with unspecified complications and need for assistance with personal care. An admission Minimum Data Set (MDS), dated Ex Order 26.4B1 revealed Resident #161 had a Brief Interview for Mental Status (BIMS) score of Ex Order indicating Ex Order 26.4B1 . The MDS indicated the resident did not have any Ex Order 26 Ex Order 26.4B1	F 641	1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice " Resident #161 was in the community for Ex Order 26.4B1 and has been discharged 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 this deficient practice " A chart review of all residents will be conducted by the two unit managers (1 on skilled and 1 on rehab) to identify any other resident(s) who may not have been assessed for appropriate oral care and nutritional care	3/21/23

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

Electronically Signed | 02/24/2023

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

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F 641	Continued From page 1 A review of Resident #161's "Nursing Admission/Readmit Screening/History," dated Ex Order 26.4B1 indicated the resident did not have Ex Order 26.4B1. A review of Resident #161's "Nutrition Risk Assessment for Short-Term Stay - Initial," dated Ex Order 26.4B1, revealed the resident did not have Ex Order 26.4B1. On 02/06/2023 at 3:26 PM, Resident #161 was observed sitting in a chair in their room watching television. The resident had Ex Order 26.4B1 Ex Order 26.4B1 Ex Order 26.4B1. During an interview on 02/07/2023 at 11:46 AM, Resident #161 Ex Order 26.4B1 During an interview on 02/07/2023 at 3:45 PM, the Director of Nursing (DON) stated there had not been a Ex Order 26.4B1 consult completed for Resident #161, since the resident had not complained of pain or trouble eating, nor had they lost any weight. She confirmed the Ex Order 26.4B1 Ex Order 26.4B1 should have been reflected on the admission MDS. During an interview on 02/08/2023 at 11:06 AM, the MDS Coordinator confirmed she completed the Ex Order 26.4B1 for Resident #161. She stated she had derived the information from the Nursing Admission/Readmit Screening/History. During an interview on 02/08/2923 at 11:16 AM, Licensed Practical Nurse (LPN) #9 indicated she completed the nursing admission assessment for	F 641	" If a resident□s assessments are found to be inaccurate, the unit manager(s) will update the assessment based upon findings " If an assessment needs to be updated, the unit manager will notify the registered dietitian and have the nutritional assessment updated to reflect the resident□s situation 3. What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur. " Nursing staff and the Registered Dietitian will be in-serviced by the Assistant Director of Nursing regarding the assessment process " Included in the in-service will be the importance of assessing and documenting residents□ mouth condition and identifying any potential issues with chewing and swallowing " The Assistant Director of Nursing will provide education to MDS and the Registered Dietician to ensure in person interviews are conducted for their assessments as required " An annual in-service will be performed by the Assistant Director of Nursing to reinforce the importance of identifying a residents□ oral care and potential issues that may result due to areas identified " Any resident noted to have poor oral health on their admission assessment will be referred to speech therapy and/or dental consult and/or physician visit; depending on the needs of the resident 4. How the facility will monitor its	

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F 641	Continued From page 2 Resident #161. She stated she noted that the resident had Ex Order 26.4B1 but did not document this on the assessment. She indicated the resident denied having Ex Order 26.4B1. She stated she did not have a reason for not documenting the resident's Ex Order 26.4B1 and indicated she should have. During an interview on 02/08/2023 at 11:26 AM, the Registered Dietitian (RD) stated she generally did not document Ex Order 26.4B1 on the Nutritional Risk Assessment unless there was an issue with Ex Order 26.4B1. During a follow-up interview on 02/08/2023 at 2:55 PM, the DON indicated the MDS and Nutritional Risk Assessment should accurately reflect Resident #161's Ex Order 26.4B1 She confirmed that with both assessments not being completed correctly there was an issue with accurate assessments. During an interview on 02/08/2023 at 3:04 PM, the Administrator stated Resident #161's MDS and Nutritional Risk Assessment should be accurately completed to ensure the resident received all the necessary care and services. A review of a facility policy titled, "Nutrition Care Nutrition Assessment/Progress Notes," dated March 2017, revealed, "Policy: All residents will receive a comprehensive nutrition assessment by a registered dietitian or authorized designee. Assessment and documentation of nutritional concerns is recorded in a timely manner in the medical record. The nutrition assessment is an in-depth evaluation of both objective and subjective data related to an individual's food and	F 641	corrective actions to ensure that the deficient practice is being corrected and will not recur. " To ensure that residents oral care is being noted on the residents admission assessment, the two Unit Managers (1 for skilled nursing and 1 for rehab) will audit 10% of the charts per each of the 4 units; audits will be conducted once per month for 3 months " The Registered Dietician will audit 10% of resident charts, once per month for 3 months to ensure the Nutritional assessment is being completed accurately " The findings of these audits will be presented at the monthly QAPI meeting. Depending on the outcome of these findings, the QAPI committee will make recommendations to continue or discontinue the audit Completion Date: March 21, 2023	

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F 641	Continued From page 3 nutrient intake, lifestyle, and medical history." New Jersey Administrative Code 8:39-11.1	F 641		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on interviews, facility policy review, and record review, it was determined the facility failed to ensure a Level II Pre-Admission Screening and Resident Review (PASRR) was conducted for 1 (Resident #61) of 3 sampled residents reviewed for PASRR. Specifically, the facility failed to refer Resident #61 for a Level II PASRR when the resident was newly diagnosed with a Ex Order 26.4B1 Ex Order 26.4B. Findings included:	F 644	1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice " Resident #61 was diagnosed with a Ex Order 26.4B1 after admission which should have resulted in a new level II PASRR " Since this discovery, resident #61 now has an updated and correct PASRR to reflect Ex Order 26.4B1 diagnosis	3/21/23

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F 644	Continued From page 4 A review of an undated facility policy titled, "PASRR," revealed the policy did not address the need to refer residents with a newly identified Ex Order 26.4B1 for a Level II PASRR screening. A review of an "Admission Record" revealed the facility admitted Resident #61 on Ex Order 26.4B1 with diagnoses including Ex Order 26.4B1 [redacted]. The record indicated the diagnosis of unspecified Ex Order 26.4B1 was added on Ex Order 26.4B1 A quarterly Minimum Data Set (MDS), dated Ex Order 26.4B1, revealed Resident #61 had a Brief Interview for Mental Status (BIMS) score of Ex Orde indicating the resident was Ex Order 26.4B1. The MDS indicated the resident had an active diagnosis of Ex Order 26.4B1 . A review of a "Pre-Admission Screening and Resident Review (PASRR) Level I Screen" with a "current assessment/authorization date" of Ex Order 26.4B1 revealed Resident #61 did not have a "diagnosis or evidence of a major Ex Order 26.4B1 limited to the following disorders: Ex Order 26.4B1, Ex Order 26.4B1 [redacted]." The screening was Ex Order 26.4B1 which indicated the resident did not require a Level II PASRR completed. A review of a "Medication Management	F 644	2. How the facility will identify other residents having the potential to be affected by the same deficient practice. " All residents that have a Ex Order 26.4B1 Ex Order 26.4B1 diagnosis or another mental disorder as classified by the PASRR have the potential to be affected by this practice " Since this deficient practice was brought to the Community's attention, the MDS Coordinators have started a chart review on all the residents. The MDS Coordinators are looking to ensure that residents who have a Ex Order 26.4B1 diagnosis or another Ex Order 26.4B1 as classified by the PASRR, have the correct PASRR " During this chart review if residents are found to not have the correct PASRR, the MDS Coordinators will notify Social Services to update the PASRR and follow the necessary requirements 3. What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur. " During the survey, it was uncovered that staff were not up to date on when the PASRR level II should be completed. As a result, an in-service will be held with the staff including: Admissions, MDS, Social Worker, Nursing, and Administration " Annually the PASRR completion process will be reviewed by the Administrator with MDS, Admissions, Social Worker and Nursing " The PASRR will be reviewed by the inter-disciplinary team at a resident's care conference and also at the time of the	

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F 644	Continued From page 5 Assessment," dated as completed Ex Order 26.4B1 revealed Resident #61 received Ex Order 26.4B1 [redacted] The assessment indicated a gradual dose reduction was not recommended for the medication due to the resident having a Ex Order 26.4B1 with Ex Order 26.4B1 . Ex Order 26.4B1 [redacted] [Ex Order 26.4B1] consult." During an interview on 02/07/2023 at 3:42 PM, Certified Social Worker (CSW) #7 stated she was responsible for ensuring PASRRs were completed and indicated Resident #61's Level 1 PASRR was completed on Ex Order 26.4B1. She acknowledged the resident had a diagnosis of Ex Order 26.4B1 added to their diagnosis list on Ex Order 26.4B1 and stated she did not refer the resident for a Level II PASRR because she was not trained to do this when a resident received a new Ex Order 26.4B1 diagnosis. She stated she was last trained approximately three years ago on how and when to complete PASRRs. During an interview on 02/08/2023 at 11:55 AM, Minimum Data Set (MDS) Coordinator #6 stated Resident #61 was given the diagnosis of Ex Order 26.4B1 from the Nurse Practitioner (NP) due to the resident Ex Order 26.4B1 During an interview on 02/08/2023 at 12:26 PM, Registered Nurse (RN) #5 and MDS Coordinator #6 both stated Resident #61 received the Ex Order 26.4B1 diagnosis due to the resident's symptoms and behaviors. MDS Coordinator #6	F 644	annual MDS submissions " The Community's PASRR policy will be updated to include when level II PASRRs should be completed 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. " In order to ensure that the deficient practice does not happen again the MDS Coordinators will audit 10 charts per month x3 months to ensure that the PASRR is being completed appropriately " Results from these audits will be shared during the monthly QAPI meetings. Based upon the results of the audits, the QAPI team will make recommendations to continue, modify or discontinue the audit Completion Date: March 21, 2023	

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F 644	Continued From page 6 stated a PASRR Level I should be completed upon admission and indicated she did not know what the Resident Assessment Instrument (RAI) Manual stated regarding when or if a PASRR Level II should be completed. MDS Coordinator #6 stated she was not aware of any other PASRR screening that should be completed for the resident. During an interview on 02/08/2023 at 12:40 PM, Medical Doctor (MD) #4 stated Resident #61 had been seen by Ex Order 26.4B1 during the resident's stay at the facility, and the Ex Order 26.4B1 staff gave the resident the diagnosis of Ex Order 26.4B1 due to the Ex Order 26.4B1, Ex Order 26.4B1. MD #4 stated she did not know about PASRRs or when they needed to be completed. During an interview on 02/08/2023 at 3:18 PM, the Director of Nursing (DON) and Administrator stated a PASRR Level I should be completed prior to admission to the facility. The DON stated she was not aware a PASRR Level II should have been completed for Resident #61 after the diagnosis of Ex Order 26.4B1 was added. She stated PASRRs were completed by the referring hospital or the social worker. The Administrator stated she did not believe the facility had to complete a Level II PASRR for the resident after the diagnosis of Ex Order 26.4B1 was added. The Administrator stated CSW #7 was responsible for completing PASRRs, and CSW #7 had received training online on PASRRs. The Administrator stated she expected staff to have proper training and be up to date with training on PASRRs. During a follow-up interview on 02/08/2023 at 3:57 PM, the Administrator stated CSW #7's last	F 644		

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F 644	Continued From page 7 training was completed by the New Jersey Department of Human Services in 2015 via a webinar.	F 644		
F 656 SS=D	New Jersey Administrative Code 8:39-5.1(a). Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes.	F 656		3/21/23

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F 656	Continued From page 8 (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review, and facility policy review, it was determined the facility failed to ensure a care planned intervention for daily inspections of a resident's Ex Order 26 was implemented for 1 (Resident #161) of 3 residents reviewed for Ex Order 26.4B1 Ex Order 26.4B1 A review of an "Admission Record" indicated the facility admitted Resident #161with diagnoses that included Ex Order 26.4B1 us with unspecified complications and need for assistance with personal care. An admission Minimum Data Set (MDS), dated Ex Order 26.4B1, revealed Resident #161 had a Brief Interview for Mental Status (BIMS) score of Ex Order which indicated moderate Ex Order 26.4B1 . The MDS indicated Resident #161 required supervision with Ex Order 26.4B1 and did not have any Ex Order 26.4B1 A review of Resident #161's "Care Plan," revised	F 656	1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice " Resident #161 was assessed upon admission to require daily inspections of Ex Order 26.4B1 due to Ex Order 26.4B1 . Resident #161 was discharged on Ex Order 26.4B prior to the survey exit. As a result, the daily Ex Order 26 inspections could not be added. " The daily Ex Order 26 inspections were noted on the residents comprehensive care plan as a care planned intervention. The intervention was not followed by the nursing team because daily Ex Order 2 inspections weren□t transcribed from the comprehensive care plan to the resident□s Treatment Administration Record " As soon as the DON was notified that the daily Ex Order inspections were not being completed a full head to toe skin assessment was completed on the	

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F 656	Continued From page 9 01/26/2023, revealed the resident had a diagnosis of Ex Order 26.4B1. Interventions included that staff were to check the resident's body for breaks in skin and treat promptly as ordered by the doctor and inspect the resident's Ex Order 26.4B1, Ex Order 26.4B1. A review of Resident #161's "Progress Note," dated Ex Order 26.4B1 at 10:56 PM, revealed the admission summary was completed at 7:00 PM and noted the resident's Ex Order 26.4B1 and their Ex Order 26.4B1. A review of Resident #161's Ex Order 26.4B1 "Treatment Administration Record (TAR)" revealed a skin assessment was completed on 01/28/2023. The daily inspections of the resident's Ex Order 26.4B1 were not addressed on the Ex Order 26.4B1 TARs. A review of Resident #161's "Skilled Nursing Care Notes," dated Ex Order 26.4B1, revealed Resident #161's Ex Order 26.4B1 and in need of a Ex Order 26.4B1 consult. A review of Resident #161's "Skilled Nursing Care Notes," dated Ex Order 26.4B1, revealed the resident was noted to have Ex Order 26.4B1 in need of a Ex Order 26.4B1. A review of Resident #161's "Skin Observation" task dated from Ex Order 26.4B1 revealed skin assessments were done daily without Ex Order 26.4B1 areas noted. During an interview on 02/09/2023 at 10:30 AM, Certified Nurse Assistant (CNA) #15 stated the	F 656	resident 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 this deficient practice " In order to make sure that the Community follows the comprehensive care plan for all residents, the unit managers (1 for skilled and 1 for rehab) will review all resident charts to ensure the daily skin assessment was transcribed to the Treatment Administration Record " If residents are identified as not having the daily skin assessments carried over to the Treatment Administration Record, the unit managers will make the correction and complete a skin assessment " Education regarding properly developing and implementing a comprehensive care plan will be provided by the unit manager to the nurse that initiated the intervention 3. What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur. " The Assistant Director of Nursing will in-service all nursing staff regarding the importance of implementing a comprehensive care plan and all required interventions. The in-service will include how and where to document all interventions so that they may be followed by other staff members " Nursing staff will be educated by the Assistant Director of Nursing on proper documentation and completion for any	

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F 656	Continued From page 10 nurses did the weekly skin assessments on shower days, which were Saturdays. The CNAs looked daily at the residents' Ex Order 26.4B1, and Ex Order 26.4B1 et cetera, and if they saw anything they told the nurse. The nurses also looked at the Ex Order 26 for residents diagnosed with Ex Order 26.4B1. CNA #15 stated she knew about Resident #161's Ex Order 26 because the resident was complaining about the condition of their Ex Order 26 upon admission and wanting to see a Ex Order 26.4B1. The CNA indicated she informed the nurse but did not recall which nurse. During an interview on 02/09/2023 at 10:45 AM, Registered Nurse (RN) #11 stated the nurses checked the Ex Order 26.4B1 residents daily when the task showed up on the TAR. She indicated the nurses did not use the care plan, so if the task was not addressed on the TAR, the nurses did not know to do it. She reviewed Resident #161's TAR and confirmed the daily Ex Order 26 inspections were not addressed. She stated the first time she saw Resident #161's Ex Order was "the other day" when the surveyor brought this to her attention. During an interview on 02/09/2023 at 10:56 AM, the Director of Nursing (DON) stated developing the care plan was a collaborative effort that started with the admission nurse. She reviewed Resident #161's care plan and stated RN #14 had completed the portion regarding the daily Ex Order inspections. During an interview on 02/09/2023 at 11:08 AM, RN #14 confirmed she was the one who developed the portion of Resident #161's care plan that addressed the daily Ex Order 2 inspections due	F 656	diabetic residents requiring daily Ex Order checks " Nursing staff will be educated by the Assistant Director of Nursing on proper documentation and completion of weekly skin assessments 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. " The Assistant Director of Nursing will audit 10 charts per month x 3 months to ensure that care plan interventions are being transcribed and implemented " The Assistant Director of Nursing will report the findings of the audit at the monthly QAPI meetings. Based upon the results, the QAPI team will determine if it is necessary to continue, modify or discontinue the care plan intervention audit Completion date: March 21, 2023	

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	315499	A. BUILDING _____ B. WING _____	02/09/2023

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F 656	Continued From page 11	F 656		

to the resident's diagnosis of Ex Order 26.4B1. She indicated she was also the person responsible to input that task on the TAR so the nurses would know to complete the task. She stated she forgot to include the Ex Order 2 inspections on Resident #161's TAR.

During a follow-up interview on 02/09/2023 at 3:01 PM, the DON stated the facility had recently changed its process regarding weekly skin assessments and daily Ex Order 2 assessments for Ex Order 26.4B1 to an evaluation and this was where the assessments should be documented. She indicated she did not know why the assessments were not documented for Resident #161 and stated not following the care plan put Resident #161 at risk for unidentified Ex Order 26.4B1 issues. She also stated all assessments should be accurately documented and the care plan should be followed.

During an interview on 02/09/2023 at 3:23 PM, the Administrator indicated daily Ex Order 2 assessments and weekly Ex Order 2 assessments should have been done for Resident #161 to identify actual or potential issues with their Ex Order 26 She also indicated not doing so could put the resident at risk for developing avoidable issues and delaying necessary treatment to the resident's Ex Order 26

A review of an undated facility policy titled, "Care Plans-Comprehensive," revealed, "Policy: A comprehensive care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident."

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F 656	Continued From page 12 New Jersey Administrative Code 8:39-11.1	F 656		
F 687 SS=D	Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. This REQUIREMENT is not met as evidenced by: Based on observations, record review, interviews, and facility document and policy review, it was determined the facility failed to provide Ex Order 26.4B1 care and services to prevent potential Ex Order 26.4B1 complications for 1 (Resident #161) of 3 sampled residents reviewed for Ex Order 26.4B1 management. A review of Resident #161's "Admission Record" revealed the resident had diagnoses that included Ex Order 26.4B1 with unspecified complications and need for assistance with personal care. An admission Minimum Data Set (MDS) dated Ex Order 26.4B1 revealed Resident #161 had a Brief Interview for Mental Status (BIMS) score of Ex Order indicating Ex Order 26.4B1. The MDS indicated the resident had Ex Order 26.4B1, Ex Order 26.4B1.	F 687	1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice " Resident #161 is no longer in the Community as they were here for sub-acute rehab and have discharged 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. " Any resident who requires Ex Order care to be performed has the potential to be affected by this deficient practice " The Unit Managers (1 for Skilled and 1 for Rehab) will review the care plans of the residents who are diabetic to ensure that Ex Order care and any potential follow-up by an outside practitioner is included in the residents care plan	3/21/23

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F 687	Continued From page 13 A review of Resident #161's "Care Plan," revised 01/26/2023, indicated the resident had Ex Order 26.4B1 Ex Order 26.4B1 and goals that included being free from signs/symptoms of Ex Order 26.4B1 (Ex Order 26.4B1 Ex Order 26.4B1 and having no complications related to Ex Order 26.4B1 through the review date. Interventions included that staff were to check the resident's body for breaks in skin and treat promptly as ordered by the doctor and to inspect the resident's Ex Order 2 daily for Ex Order 26.4B1 , Ex Order 26.4B1 . A review of Resident #161's "Admission Assessment," dated Ex Order 26.4B1 revealed no documentation regarding any Ex Order 26 issues. A review of Resident #161's "Progress Note," dated Ex Order 26.4B1 at 10:56 PM, revealed Resident #161's admission summary was completed at 7:00 PM and noted the resident's Ex Order 26.4B1 and their Ex Order 26.4B1 . A review of Resident #161's Ex Order 26.4B1 "Treatment Administration Record (TAR)" revealed a skin assessment was completed on Ex Order 26.4B1 A review of Resident #161's "Skilled Nursing Care Notes," dated Ex Order 26.4B1 revealed the resident's Ex Order 26.4B1 and in need of a Ex Order 26.4B1 consult. A review of Resident #161's "Skilled Nursing Care Notes," dated Ex Order 26.4B1 , revealed the resident was noted to have Ex Order 26.4B1 in need of a Ex Order 26.4B1 .	F 687	" The Unit Managers will review the charts for documentation for Ex Order 2 care and that any necessary follow-up is being provided to the resident " If the Unit Manger discovers that the Ex Order 2 care is not being provided, she will add this to the resident□s care plan and provide education to the nurse that didn□t properly complete the care plan 3. What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur. " All nursing staff will be in-serviced by the Director of Nursing about the importance of providing Ex Order care to residents who are diabetic and/or anyone determined to need Ex Order 2 care " Nursing staff will be educated by the Director of Nursing about when an outside practitioner should be consulted to assist in maintaining good Ex Order 2 health to residents " Nursing staff will be educated by the Director of Nursing on assessment and implementation of Ex Order 2 care for residents 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. " The Director of Nursing will conduct an audit on 10 charts per month x 3 months to determine if residents who require Ex Order care are receiving skin assessments weekly and any necessary outside support from practitioners. " These findings will be presented and discussed at the monthly QAPI meetings.	

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F 687	Continued From page 14 On 02/06/2023 at 11:05 AM, Resident #161 was observed sitting in a chair in their room watching television. During an interview at this time, the resident indicated their only concern was that the facility was not addressing their Ex Order 26 Resident #161 removed their Ex Order 26.4B1 to show the condition of their Ex Order 26 and said the Ex Order 26.4B1 was Ex Order 26.4B1. The Ex Order 26.4B1 and had Ex Order 26.4B1 . The Ex Order 26.4B1 were Ex Order 26.4B1, Ex Order 26.4B1 , and Ex Order 26 Ex Order 26.4B1 Resident #161 stated facility staff had told the resident they could not do anything about it and would have the Ex Order doctor come and take care of them on three different days. The resident indicated the Ex Order 26 doctor had not come on any days the facility told them they would be there. The resident also indicated that no one had checked their Ex Order 26 daily. On 02/07/2023 at 11:42 AM, Resident #161 was observed sitting in a chair in their room wearing Ex Order 26.4B1. Resident #161's Ex Order 26 were not Ex Order 26.4B1. During an interview at this time, Resident #161 stated they still had not received Ex Order 26.4B1 The resident indicated they felt that if their Ex Order 26.4B1 were not in such Ex Order 26.4B1, they would get more out of therapy. During an interview on 02/07/2023 at 11:57 AM, Registered Nurse (RN) #11 stated the Ex Order 26.4B1 would have to take care of Resident #161's Ex Order 2, and she would tell the unit clerk. RN #11 indicated she had been told the resident had been informed that a Ex Order 26.4B1 would come and see them on three different occasions, but no one had shown up. RN #11 stated she would check on this right away. She left briefly, then returned and entered	F 687	Based upon the results of the audit, the QAPI committee will made recommendations to continue, modify or discontinue the audit Completion date: March 21, 2023	

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F 687	Continued From page 15	F 687		

the resident's room. She told the resident she would be right back to check their [redacted] and denied having any knowledge of the condition of the resident's [redacted]

On 02/07/2023 at 12:00 PM, RN #11 was observed to reenter Resident #161's room. The RN removed the [redacted] from the resident's [redacted] The [redacted], with [redacted] There was a [redacted], and the resident's [redacted]. RN #11 left the room and returned with Nurse Practitioner (NP) #12.

On 02/07/2023 at 12:18 PM, NP #12 was observed entering Resident #161's room to assess the resident's [redacted] After assessing the resident's [redacted] the NP provided orders for [redacted] and to get an appointment right away with [redacted]. He then left the room and reentered at 12:23 PM and told Resident #161 that [redacted] would see them that day and to [redacted] as much as possible to help with the [redacted].

On 02/07/2023 at 2:00 PM, the Director of Nursing (DON) provided a copy of Resident #161's January 2023 Treatment Administration Record (TAR). A review of the document revealed Licensed Practical Nurse (LPN) #13 documented he had completed a weekly skin assessment on 01/28/2022. There was no documentation of any specific findings from the assessment.

During a phone interview on 02/07/2023 at 2:18 PM, LPN #9 stated she had done Resident #161's Admission Assessment the evening they were [redacted]. She indicated she had done a

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F 687	Continued From page 16 head-to-toe assessment and had noted Resident #161 had Ex Order 26.4B1 , which, when the dressings were removed, Ex Order 26.4B1 LPN #9 also indicated she had documented all of this on the admission assessment under Ex Order 26.4B1." She stated she had reported the assessment to the oncoming nurse. On 02/08/2023 at 9:59 AM during a telephone interview, LPN #13 stated he remembered doing the skin assessment on Saturday, 01/28/2023, which was Resident #161's shower day. He stated he noted the resident's Ex Order 26.4B1 during the assessment that day. He indicated he had also looked at the resident's Ex Order 26 the night before due to Resident #161 telling him about the condition of their Ex Order 2 and indicated that was when he faxed a referral to Ex Order 26.4B1. LPN #13 stated he did not know why he did not document either assessment but indicated he should have. He stated he had only checked Resident #161's Ex Order 26.4B1 . During an interview on 02/08/2023 at 3:01 PM, the Director of Nursing (DON) indicated the facility had recently changed its process regarding weekly skin assessments and daily Ex Order 26 assessments for diabetics to an evaluation, where the assessments should be documented. She stated she did not know why the assessments were not documented for Resident #161. She indicated not following the care plan put Resident #161 at risk for unidentified skin and Ex Order 26 issues. She stated all assessments should be accurately documented and the care plan should be followed.	F 687		

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F 687	Continued From page 17 During an interview on 02/08/2023 at 3:23 PM, the Administrator indicated daily [Ex Order 2] assessments and weekly skin assessments should have been done for Resident #161 to identify actual or potential issues with their [Ex Order 26] She also indicated that not doing so could put the resident at risk for developing avoidable issues and delaying the necessary treatment to the resident's [Ex Order 26] As of the survey exit on 02/09/2023, the facility had been unable to provide documentation of daily [Ex Order 26] assessments, as care planned for Resident #161. A review of an undated facility policy titled, "Diabetes - Clinical Protocol," revealed, "Policy: To provide appropriate care and attention to residents who are diabetic." The "Skin and Foot Care" section of the policy included, "3. Report any changes of skin condition immediately. 4. Consult Podiatry for all foot/toenail routine and as needed."	F 687		
F 803 SS=E	New Jersey Administrative Code 8:39-11.1 Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed;	F 803		3/21/23

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F 803	Continued From page 18 §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, facility document review, and facility policy review, it was determined that the facility failed to follow the planned menu and serve foods to residents in the amount indicated on the diet spreadsheet for 2 of 2 meals observed. This had the potential to affect 71 residents who received meals from the kitchen, as identified by the facility. Findings included: Review of a facility policy titled, "Menu Extensions/Diet Spreadsheets," dated 01/2016, revealed, "Policy: Menu extensions are to be available, referred to, and followed with each meal that is prepared and served. 1. Each employee is responsible for following the prepared menu extensions. 3. When serving, the employee refers to the menu extension to ensure that the proper portion sizes and diet needs are being met."	F 803	1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice " Portion control in-services were immediately conducted for the dining service aids 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 will not recur. " The General Manager of Food and	

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F 803	Continued From page 19 Review of the facility policy titled, "Diets and Menus Portion Control," dated 03/2017, specified, "Policy: Standardized portions of food will be planned and served for all menu items to ensure standards for nutritional content and food cost are met. 1. Portion sizes will be indicated on menu extensions and production sheets. 3. The correct type and size of utensils will be used for each menu item." The policy further indicated a #8 scoop held 4 ounces (oz.), a #10 scoop held 3 1/4 oz., a #12 scoop held 2.67 oz., and a #16 scoop held 2 oz. 1. A review of the "Diet Extensions Week #3 Monday Lunch" specified a regular diet included: - 6 ounces (oz.) of navy bean soup, - 1/2 cup (c.) of sliced pears, - 2 oz. of turkey with two slices of bread and 1 oz. of cranberry sauce, - 1/2 c. of green beans, - 1/2 c. of mashed potatoes, and - one oatmeal cranberry cookie. Alternates for the regular diet included 3 oz. of roast beef on one slice of bread, and 4 oz. of tomato corn salad. A mechanical soft-chopped meats diet included: - 6 oz. of navy bean soup, - 1/2 c. of sliced pears, - 2 oz. of chopped turkey on white bread with no crust and 1 oz. of cranberry sauce, - 1/2 c. of green beans, - 1/2 c. of mashed potatoes, and - one oatmeal cranberry cookie. Alternates for the mechanical soft-chopped meats diet included 3 oz. of chopped beef on one slice of white bread with no crust, and 4 oz. of [redacted] juice. A mechanical soft-ground meats diet included:	F 803	Nutrition Services provided immediate in-services to the dining service aids regarding portion control tools and appropriate serving sizes for all menu items as stated on the diet extensions " Portion control posters were posted in each service pantry " Menus including the portion sizes for each menu item will be available in each service pantry for the dining service aids to reference 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. " The General Manager of Food and Nutrition Services will provide in-services monthly to staff for 3 months on portion control tools and appropriate serving sizes for each menu item using the diet extensions " The General Manager of Food and Nutrition Services will conduct random audits twice weekly for 3 months in the service pantries to ensure that correct portion sizes are being provided and that the menu including the portion sizes for each food item are present " The Registered Dietician will complete a monthly QAPI report X3 months reviewing the results of the portion control audits. The finding of the audits will be presented at the monthly QAPI meeting " The frequency of the audits will be adjusted based on satisfactory results of these audits. Depending on the outcome of these findings, the QAPI committee will	

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F 803	Continued From page 20 - 6 oz. of navy bean soup, - 1/2 c. of sliced pears, - 2 oz. of ground turkey on white bread with no crust and 1 oz of cranberry sauce, - 1/2 c. of green beans, - 1/2 c. of mashed potatoes, and - one oatmeal cranberry cookie. Alternates for the mechanical soft-ground meats diet included 3 oz. of ground beef on 1 slice of bread with no crust, and 4 oz. of [redacted] juice. A full ground diet included: - 6 oz. of pureed navy bean soup, - #8 scoop (4 oz.) pureed pears, - 2 oz. of ground turkey on #12 scoop (2.67 oz.) pureed bread with 1 oz. of cranberry sauce, - #8 scoop (4 oz.) of pureed green beans, - 1/2 c. of mashed potatoes, and - #12 scoop (2.67 oz.) of pureed oatmeal cranberry cookie. Alternates for the full ground diet included 3 oz. of ground beef with #16 scoop (2 oz.) of bread, and 4 oz. of [redacted] juice. On 02/06/2023 (Monday) from 12:30 PM to 1:07 PM, Dining Room Service Aide (DRSA) #1 was observed plating the first floor skilled lunch menu items for the resident lunch meal trays. For regular diets, DRSA #1 was observed using a 4 oz. ladle to plate navy bean soup, using a tong to plate turkey, and a #12 scoop to plate mashed potatoes. For the regular alternates diets, DRSA #1 was observed using a tong to plate roast beef, and a 3 oz. ladle to plate tomato corn salad. For a mechanical soft-chopped meat diet, DRSA #1 was observed using a 4 oz. ladle to plate navy bean soup, a tong to plate chopped turkey, and a #12 scoop to plate mashed potatoes. For mechanical soft-chopped meat diet alternates, DRSA #1 was observed using a #16 scoop of	F 803	make recommendations to continue or discontinue the audit Completion Date: March 21, 2023	

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F 803	Continued From page 21 chopped beef. No [Ex Order 2] juice was served. For a mechanical soft-ground meat diet, DRSA #1 was observed using a 4 oz. ladle to plate navy bean soup, using a tong to plate ground turkey, and a #12 scoop to plate mashed potatoes. For mechanical soft-ground meat diet alternatives, DRSA #1 was observed using a #16 scoop of ground beef. No [Ex Order 2] juice was served. During an interview on 02/06/2023 at 1:09 PM, DRSA #1 revealed that she used a 4 oz. ladle to serve navy bean soup, 4 oz. ladle to serve gravy, #12 scoop for mashed potatoes, #16 scoop for ground roast beef, a tong to serve regular and chopped turkey, and 3 oz. ladle to plate tomato corn salad. She indicated the menu with serving sizes was not present during the meal service and she sometimes looked at the menu when it was brought to her from the main kitchen. DRSA #1 stated she expected the menu, including serving sizes, to be followed. 2. Review of the "Diet Extensions Week #3 Tuesday Lunch" specified a regular diet included: - 6 oz. of split pea soup, - 1/2 c. of mandarin oranges, - one slice of [Ex Order 2B.4SH] and tomato frittata, - 1/2 c. of sweet potato wedges, - 1/2 c. of spinach salad, and - one slice of cherry pie. Alternates for the regular diet included a #10 scoop (3.25 oz.) of tuna melt with cheese on sliced bread, and 8 oz. of milk. A mechanical soft-chopped meat diet included: - 6 oz. of split pea soup, - 1/2 c. of mandarin oranges, - one slice of [Ex Order 2B.4SH] and tomato frittata, - 1/2 c. of sweet potato wedges with no skin, - 4 oz. of tomato juice, and	F 803		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315499	A. BUILDING _____ B. WING _____	02/09/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 803	Continued From page 22 - one slice of cherry pie. Alternates of the mechanical soft-chopped meat diet included #10 scoop (3.25 oz.) of tuna melt with cheese on sliced bread without crust, and 8 oz. of milk. A mechanical soft-ground meat diet included: - 6 oz. of split pea soup, - 1/2 c. of mandarin oranges, - one slice of [redacted] and tomato frittata, - 1/2 c. of sweet potato wedges with no skin, - 4 oz. of tomato juice, and - one slice of cherry pie. Alternates for the mechanical soft-ground meat diet included a #10 scoop (3.25 oz.) of tuna melt with cheese on sliced bread without crust, and 8 oz. of milk. A full ground diet included: - 6 oz. pureed split pea soup, - #8 scoop (4 oz.) of pureed mandarin oranges, - 3 oz. of ground frittata, - #10 scoop (3.25 oz.) of mashed sweet potato, - 4 oz. of tomato juice, and - #12 scoop (2.67 oz.) of pureed cherry pie. Alternates for the full ground diet included #10 scoop (3.25 oz.) of tuna salad and #12 scoop (2.67 oz.) of pureed bread, and 8 oz. of milk. A puree diet included: - 6 oz. pureed split pea soup, - #8 scoop (4 oz.) of pureed mandarin oranges, - 3 oz. of pureed frittata, - #10 scoop (3.25 oz.) of mashed sweet potato, - 4 oz. of tomato juice, and - #12 scoop (2.67 oz.) of pureed cherry pie. Alternates for the puree diet included a #10 scoop (3.25 oz.) of tuna salad and #12 scoop (2.67 oz.) of pureed bread, and 8 oz. of milk. On 02/07/2023 (Tuesday) from 12:10 PM to 12:52 PM, DRSA #2 was observed plating the	F 803		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315499	A. BUILDING _____ B. WING _____	02/09/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 803	Continued From page 23	F 803		

second-floor skilled lunch menu items for the resident lunch meal trays. For regular diets, DRSA #2 was observed using a 3 oz. ladle to plate mandarin oranges and a tong to plate spinach salad. For mechanical soft-chopped meat and mechanical soft-ground meat diets, DRSA #2 was observed using a 3 oz. ladle to plate mandarin oranges and a tong to plate spinach salad. For full ground diets, DRSA #2 was observed using a #12 scoop to plate pureed oranges, #12 scoop to plate ground frittata, #16 scoop to plate pureed sweat potato, and #16 scoop to plate tuna melt. For pureed diets, DRSA # 2 was observed using a #12 scoop to plate pureed oranges, #16 scoop to plate pureed frittata, #16 scoop to plate pureed sweet potatoes, and #16 scoop to plate tuna melt.

On 02/07/2023 at 12:53 PM, DRSA #2 stated she used a #16 scoop to plate puree tuna, #16 scoop for pureed sweet potatoes, #16 scoop for puree frittata, #12 scoop for pureed oranges, #12 scoop to plate ground frittata, and a tong to serve salad. She stated that when using a tong, you do not know how much the resident was getting served. DRSA #2 stated the main kitchen sent the serving utensils to the kitchenettes and was supposed to send the correct serving sizes for the meals. She stated she normally looked at the menu but did not get a menu to look at for that meal and could not ask for a menu because her radio, to call the main kitchen, was not working. She stated she expected the menu to be followed.

On 02/08/2023 at 11:25 AM, Registered Dietician (RD) #10 stated the menu and serving sizes should be followed. She stated she completed audits for textures but not for staff using the correct serving sizes according to the menu. She

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	315499	A. BUILDING _____ B. WING _____	02/09/2023

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

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F 803	Continued From page 24	F 803		

indicated potential negative outcomes of not serving the correct portions included residents not getting enough calories and protein which could lead to weight loss. RD #10 stated she expected serving sizes and the menu to be followed.

On 02/08/2023 at 11:56 AM, DRSA #1 stated she trusted the main kitchen to send the correct serving utensils. She indicated she did not have a menu to look at on Monday (02/06/2023) to look at the serving sizes indicated on the menu. She stated she expected the serving sizes and menus to be followed. She stated she did not receive training on checking the menu serving sizes.

On 02/08/2023 at 12:11 PM, General Manager for Dining Services (GMDS) #16 revealed DRSAs were trained to follow the menu and serving sizes. He stated DRSA #1 had been employed by the facility for a couple of years but the other DRSAs were fairly new. He indicated the kitchen managers were responsible for ensuring the menu was followed. He stated the potential negative outcome of residents not getting the correct portion sizes was weight loss. GMDS #16 stated he would ensure the correct serving utensils were provided to the kitchenettes on each floor and expected the menu and serving sizes to be followed.

On 02/09/2023 at 7:39 AM, the Administrator stated she expected the menu and serving sizes to be followed. She stated the kitchen managers were responsible for ensuring the staff serving in the kitchenettes had the correct serving utensil sizes needed to serve the meal. The Administrator stated she did not monitor serving sizes used during meals, but the dietician and kitchen managers were responsible for

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	315499	A. BUILDING _____ B. WING _____	02/09/2023

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

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F 803	Continued From page 25 monitoring such practices. She stated tongs could not measure portions. She stated the potential negative outcome of residents not getting the correct portion sizes was undernourishment. On 02/09/2023 at 8:33 AM, the Director of Nursing (DON) stated the serving sizes, based on the menu/diet spreadsheet, should be followed. She stated the kitchen managers and dietician were responsible for checking that the correct serving sizes were being used according to the menu. She stated she never watched meal service to ensure the serving sizes being used matched the menu but would start monitoring. She expected the menu and serving sizes to be followed to maintain the nutritional adequacy of the residents' meals. New Jersey Administrative Code § 8:39-17.4(a)(3)	F 803		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04002	A. BUILDING: _____ B. WING _____	02/09/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Census: 99 Sample Size: 20 TYPE OF SURVEY: Recertification The facility is not in substantial compliance with all of the standards in the New Jersey Administrative Code 8:39, Standards for Licensure of Long-Term Care Facilities. The facility must submit a plan of correction, including a completion date for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with provisions of New Jersey Administrative Code Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on interviews, facility document review, and New Jersey Department of Health (NJDOH) memo, dated Ex Order 26.4B1, it was determined that the facility failed to ensure staffing ratios were met for 4 of 42 shifts reviewed. This deficient practice had the potential to affect all residents. Findings included: Reference: NJDOH memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes	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	3/21/23

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

Electronically Signed — 02/24/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04002	A. BUILDING: _____ B. WING _____	02/09/2023

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

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S 560	Continued From page 1 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 at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were in effect 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 than half of all staff members shall be certified nurse aides, and each direct staff member shall be signed in to work as a certified nurse aide and shall perform certified 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 certified nurse aide and perform certified nurse aide duties. A review of the "Nurse Staffing Report," completed by the facility for the weeks of 01/22/2023 - 02/04/2023, revealed staff-to-resident ratios that did not meet the minimum requirements as listed below: 01/22/2023 - 12 CNAs to 105 residents on the day shift. 01/24/2023 - 12 CNAs for 102 residents on the day shift. 01/29/2023 - 11 CNAs for 97 residents on the day shift. 02/01/2023 - 11 CNAs for 95 residents on the day shift.	S 560	affected by the deficient practice 3. What measures will be put into place or systemic changes made to ensure that the deficient practice would not recur. " The community will continue with recruitment efforts to obtain additional staff. Recruitment efforts include: employee referral bonus, job fairs, social media job postings, sign on bonus, job posting on community website and Indeed " 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 " The community will continue to utilize agency staff for open shifts that need coverage " The community will work to engage additional staffing agencies for services " 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 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. " The staffing coordinator will audit the staffing ratios daily and report deficient shifts to the Director of Nursing and Administrator " The staffing coordinator will report the findings of the deficient shifts at the monthly QAPI meeting x□s 3 months. Based upon the results, the QAPI team will determine if it is necessary to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04002	A. BUILDING: _____ B. WING _____	02/09/2023

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S 560	Continued From page 2 During an interview on 02/08/2023 at 1:54 PM, Staffing Coordinator (SC) #3 stated the New Jersey staffing requirement for day shift was one CNA per eight residents, for evening shift it was one direct care staff member per ten residents, and for night shift it was one care member per 14 residents. SC #3 stated the facility never fell below the requirements. SC #3 reviewed the day shift of 01/22/2023 and stated the facility had 12 CNAs and should have had 13 CNAs. SC #3 stated that was on a Sunday, and the weekend supervisor handled the staffing on the weekends. SC #3 reviewed the day shift documentation of 01/24/2023 and stated the facility had 12 CNAs and should have had 13 CNAs. SC #3 reviewed the day shift of 01/29/2023 and stated the facility had 11 CNAs and should have had 12 CNAs. She stated if another aide had been scheduled for the rehabilitation section of the facility, they would have had enough CNAs. SC #3 reviewed the day shift for 02/01/2023 and stated the facility had 11 CNAs and should have had 12. After reviewing the dates when the facility was short by one CNA, SC #3 stated the facility did fall below the state requirement for CNA-to-resident ratio. During an interview on 02/08/2023 at 3:18 PM, the Administrator and Director of Nursing (DON) were interviewed together. The Administrator stated the facility policy indicated the facility followed CMS guidelines regarding staffing and she could add the New Jersey staffing requirements to the policy. The DON stated the staffing ratio for day shift was one CNA per eight residents, evening shift was one CNA per ten residents, and night shift was one CNA per fourteen residents. The DON stated the facility tried to follow the ratio guidelines and used agency staff. The Administrator stated the facility had also pulled their unit secretaries because	S 560	continue, modify or discontinue the staffing audit Completion date: March 21, 2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	04002	A. BUILDING: _____ B. WING _____	02/09/2023

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

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S 560	Continued From page 3 they were also certified as CNAs. The Administrator and DON went over the dates of 01/22/2023, 01/24/2023, 01/29/2023, and 02/01/2023 day shift staffing numbers and stated they were short staffed by one CNA on the day shift for those dates. Both the DON and Administrator indicated their expectation was to have the facility fully staffed per the New Jersey requirements. An undated policy titled, "Staffing," indicated, "Our facility provides sufficient numbers of staff with the skills and competency necessary to provide care and services for all residents in accordance with resident care plans and CMS guidelines. 2. Staffing numbers of direct care staff are determined by the needs of the residents based on each resident's plan of care."	S 560		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315499 Y1	A. Building B. Wing Y2	4/4/2023 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 F0641	Correction	ID Prefix F0644	Correction	ID Prefix F0656	Correction
Reg. # 483.20(g)	Completed	Reg. # 483.20(e)(1)(2)	Completed	Reg. # 483.21(b)(1)(3)	Completed
LSC	03/21/2023	LSC	03/21/2023	LSC	03/21/2023
ID Prefix F0687	Correction	ID Prefix F0803	Correction	ID Prefix	Correction
Reg. # 483.25(b)(2)(i)(ii)	Completed	Reg. # 483.60(c)(1)-(7)	Completed	Reg. #	Completed
LSC	03/21/2023	LSC	03/21/2023	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	
2/9/2023	☐ 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 A. Building B. Wing	DATE OF REVISIT
04002 (Y1)	(Y2)	4/4/2023 (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 S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 03/21/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 2/9/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315499	A. BUILDING **01** B. WING _____	**02/09/2023**

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

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E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations from 02/08/2023 through 02/09/2023 and Lions Gate was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. Lions Gate is a two-story Type II Protected building that was built in October 2007. The facility is divided into 12 smoke zones.	K 000		
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review.	K 761		3/21/23

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

Electronically Signed | 02/24/2023

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315499	A. BUILDING **01** B. WING _____	**02/09/2023**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 761	Continued From page 1 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on interview and facility document review, it was determined the facility failed to inspect all fire-rated doors as required by National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) sections 7.2.1.15.2 and 7.2.1.15.4 and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives. This had the potential to affect all 99 residents. A review of the facility's life safety code documentation on 02/08/2023 at 5:35 PM revealed no evidence of an annual inspection of all fire rated doors for the past 12 months. During an interview on 02/09/2023 at 8:03 AM, the Director of Property and Maintenance (DPM) stated the facility did not have a policy for inspecting fire rated doors. The DPM indicated he had never been asked for documentation of an annual inspection for all fire-rated doors. He stated he was not aware of the code requirements to annually inspect the fire-rated doors and had been employed by the facility for six years. The DPM stated he expected all life safety code requirements to be followed. During an interview on 02/09/2023 at 8:54 AM, the Administrator stated she was not aware of the requirements to annually inspect all fire-rated doors. She indicated the DPM was responsible for all life safety code requirements and stated she expected all life safety code requirements to be followed. On 02/09/2023 at 11:15 AM, the Administrator	K 761	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 be 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. " The annual testing/inspection of the fire doors was completed on March 3, 2023 " All fire doors will be scheduled annually to be tested/inspected " The Director of Property and Maintenance has ordered NFPA 101 Life Safety Code Book to ensure the community is up to date with all Life Safety Codes " The Director of Property and Maintenance will in-service the maintenance department on any updates and/or changes to the Life Safety Codes " The community will create a policy for the annual inspection of the fire doors " The Annual inspection of the fire doors will be added to the life safety	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315499	A. BUILDING **01** B. WING _____	**02/09/2023**

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

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K 761	Continued From page 2 provided a document that indicated there were 83 fire-rated doors in the facility. New Jersey Administrative Code § 8:39-31.6	K 761	binder and checked as part of the preventative maintenance for building systems " The report for the annual testing of the fire doors will be added to the life safety binder and reviewed annually for completion 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. " In order to ensure compliance with required and upcoming life safety inspections, the Director of Property and Maintenance will report at the monthly QAPI meetings what inspections have been completed for the current month, what the outcome of the inspection was and what inspections are due for the next month " The findings of these inspections will be presented at the monthly QAPI meeting. Depending on the outcome of these findings, the QAPI committee will make recommendations regarding any necessary or required follow up Completion Date: March 21, 2023	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a	K 918		3/21/23

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	315499	A. BUILDING 01 B. WING _____	02/09/2023

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K 918	Continued From page 3 process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on interviews, facility document review, and facility policy review, it was determined the facility failed to conduct annual testing of the emergency generator diesel fuel in accordance with National Fire Protection Association (NFPA) 99, Healthcare Facilities Code, 2012 edition, Section 6.5.4.1.1.2, which states Type I Essential Electrical System (ESS) generators shall be inspected and tested in accordance with Section	K 918	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 be affected by the deficient practice 2. How the facility will identify other residents having the potential to be	

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K 918	Continued From page 4 6.4.4.1.1.3. and NFPA 110, Standard for Emergency and Standby Power, Section 8.3.8, which requires a fuel quality test be performed at least annually using tests approved by American Society for Testing and Material (ASTM). This had the potential to affect all 99 residents. Findings included: A review of an undated facility policy titled, "Generator Policy," indicated, "Generator testing will be performed in accordance with code NFPA-110." A review of "Minor Service Reports," dated Ex Order 26.4B1 , revealed the vendor conducting the generator minor inspection and testing did not conduct an annual diesel fuel quality analysis test. A review of a "Major Service Report," dated 07/06/2022, revealed the vendor conducting the generator major inspection and testing did not conduct an annual diesel fuel quality analysis test. During an interview on 02/09/2023 at 8:05 AM, the Director of Property and Maintenance (DPM) stated he was unaware of the code requirement to complete an annual diesel fuel quality analysis. He indicated he was responsible for the facility's compliance with life safety code requirements. The DPM stated he expected all life safety code requirements to be followed. During an interview on 02/09/2023 at 8:56 AM, the Administrator stated she was not aware of the requirement to complete an annual generator diesel fuel quality analysis. She indicated the	K 918	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 diesel fuel quality analysis test was performed on February 16, 2023 " The Director of Property and Maintenance will ensure that annually a diesel fuel quality analysis test will be performed for the generator " Annual testing of the diesel fuel will be added to the generator policy " The Annual testing of the diesel fuel will be added to the life safety binder and checked as part of the preventative maintenance for building systems " The report for the annual testing of the generator diesel fuel will be added to the life safety binder and reviewed annually for completion 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. " To ensure compliance with required and upcoming life safety inspections, the Director of Property and Maintenance will report at the monthly QAPI meetings what inspections have been completed for the current month, what the outcome of the inspection was and what inspections are due for the next month " The findings of these inspections will be presented at the monthly QAPI meeting. Depending on the outcome of these findings, the QAPI committee will	

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	315499	A. BUILDING **01** B. WING _____	**02/09/2023**

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K 918	Continued From page 5 DPM was responsible for all life safety code requirements and stated she expected all life safety code requirements to be followed. New Jersey Administrative Code § 8:39-31.6	K 918	make recommendations regarding any necessary or required follow up Completion Date: March 21, 2023	

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 01 - LIONS GATE B. Wing Y2	4/4/2023 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 Reg. # NFPA 101 LSC K0761	Correction Completed 03/21/2023	ID Prefix Reg. # NFPA 101 LSC K0918	Correction Completed 03/21/2023	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
2/9/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO