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 06/12/2026

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 Intake ID#: 2567476 Survey Dates: 6/4/26 to 6/12/26 Census: 90 Sample size: 19 + 3 closed records A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F0000		07/01/2026
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by:	F0812	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? a) Can Opener: no residents were found to have been affected by the deficient practice b) Chemical Storage: no residents were found to have been affected by the deficient practice c) Dish Machine Temperature: no residents were found to have been affected by the deficient practice 2. How will you identify other residents having the potential to be affected by the deficient practice and what corrective actions will be taken? a) All residents had the potential to be affected by the deficient practice The can opener was thoroughly cleaned by the Executive Chef b) All residents had the potential to be affected by the deficient practice	07/13/2026

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

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F0812 SS = F	Continued from page 1 Based on observation, interview, and review of facility policies, it was determined that the facility failed to maintain proper kitchen sanitation practices in a manner to prevent food borne illness. This deficient practice was observed and evidenced by the following: On 6/4/26 at 9:36 AM, the surveyor conducted an interview with the U. S. FOIA (b) (2)) prior to the initial tour of the kitchen. The U. S. FOIA stated that the kitchen was Kosher which included separate kitchens, refrigerators, freezers, and dish machines for meat and dairy. On 6/4/26 at 9:48 AM, the surveyor in the presence of the U. S. FOIA (b) (2) toured the kitchen and observed the following: 1. On the chef's preparatory table, there was a can opener with a black sticky residue. The U. S. FOIA stated the can opener should be cleaned daily. 2. In the hallway outside the dishwasher area, there were three (3) white plastic buckets and four (4) white cardboard boxes stored directly on the floor underneath a 4-tiered metal rack containing chemicals. The U. S. FOIA stated that the buckets contained chemicals for the dishwasher, the boxes contained soap, and that they should not have been stored directly on the floor. On 6/4/26 at 10:30 AM, in the presence of th U. S. FOIA (b) (2) the surveyor toured the Rehab 1 Unit satellite kitchen. The surveyor observed the two (2) dish machines labeled dairy and meat. The dish machines were not being used at the time. The surveyor reviewed the Dish/Pot Machine Temperature Log sheet hanging on the wall. The U. S. FOIA stated that the dish machines were low temperature machines, and the wash cycle should be at 130 degrees Fahrenheit (F), and the rinse cycle should be at 165F. At that time the surveyor reviewed the following temperatures documented on the June 2026 Dish/Pot Machine Temperature Log: 6/1/26 Breakfast Wash(W)- 140 Rinse(R) 116 diary dish machine 6/1/26 Lunch W 154, R 138 meat dish machine	F0812	Continued from page 1 The three white plastic buckets and the four white cardboard boxes that were stored directly on the floor have been moved onto the storage rack c) All residents residing on the first floor of the Rehab had the potential to be affected by the deficient practice The dishes from the Rehab one dining room were taken to the main kitchen to be cleaned A service call was placed to the company that services the dish machines, they repaired the dish machine on Rebab one and confirmed the wash and rinse cycles are at the appropriate temperatures 3. What measures will be put into place or what system changes will you make to ensure that the deficient practice does not recur? a) Dining staff that use the can opener have been in-serviced by the Executive Chef, on proper cleaning procedures The Executive Chef will conduct daily inspections for one month and then weekly inspections for two months to ensure the can opener is being cleaned properly b) Dining staff that store chemicals have been in-serviced by the Executive Chef on proper storage procedures The Dining Manager will conduct daily rounds for one month and then weekly rounds for two months of the chemical storage area to ensure no items are stored directly on the floor c) Dining staff that work on Rehab one have been in-serviced by the Assistant Director of Dining on proper dishwasher temperatures and reporting low temperatures to their supervisor The Dining Manager will review the temperature logs	07/13/2026

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F0812 SS = F	Continued from page 2 6/1/26 Dinner W 139 R 115 meat 6/2/26 Breakfast W 139 R 115 dairy 6/2/26 Lunch W 153 R 137 meat 6/2/26 Dinner W 122 R 107 meat 6/3/26 Dinner W 137 R 118 meat 6/4/26 Breakfast W 155 R 136 dairy At that time, the [U. S. FOIA ID] stated that if the dish machines did not meet the appropriate temperatures, the staff should let the managers know so the dish machines could be serviced. The [U. S. FOIA ID] further stated that the dishes would be sent to the main kitchen to be washed until the dish machine was fixed. On 6/5/26 at 12:05 PM, during the follow up tour of the Rehab 1 Unit Kitchen, the [U. S. FOIA ID] stated that the dish machines were actually high temperature dish machines and that the wash cycle should be at 160 F and the rinse cycle should be at 180 F. On 6/8/26 at 8:40 AM, the facility provided a copy of the May 2026 Dish/Pot Machine Temperature Log for Rehab 1 Unit kitchen which revealed the following documented temperatures: 5/10/26 Breakfast W -137 dairy machine 6/11/26 Breakfast W-135 dairy 6/13/26 Breakfast W- 149 dairy 6/22/26 Dinner W 143 dairy 6/23/26 Breakfast W- 116 R 139 dairy 6/24/26 Breakfast W 114 R 136 dairy 6/24/26 Breakfast W 114 R 149 dairy 6/25/26 Breakfast W 127 R 139 dairy 6/27/26 Breakfast W 115 R 130 dairy 6/28/26 Breakfast W 135 R 129 dairy 6/28/26 Lunch W 153 R 173 meat	F0812	Continued from page 2 daily for one month and then weekly for two months for the dish machine on Rehab one to ensure the temperatures for the wash and rinse cycles are within the regulated parameters 4. How will the corrective action be monitored to ensure that the deficient practice does not recur (QA)? Who will be responsible? a) The Assistant Director of Dining will audit the findings of the inspections conducted by the Executive Chef and report them to the QAPI committee monthly for a minimum of three months b) The Assistant Director of Dining will audit the findings of the rounds conducted by the Dining Manager and report them to the QAPI committee monthly for a minimum of three months c) The Assistant Director of Dining will audit the review of the temperature logs to ensure the wash and rinse cycle temperatures are within the regulated parameters and will present the results to the QAPI committee monthly for a minimum of three months	07/13/2026

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F0812 SS = F	Continued from page 3 6/30/26 Breakfast W 124 dairy On 6/8/26 at 12:39 PM, the surveyor interviewed the U. S. FOIA (b) (2) [redacted] in the presence of the survey team. The U. S. FOIA (b) [redacted] stated that the high temperature dish machines should have a wash cycle of 160 F and a rinse cycle of 180 F. The U. S. FOIA (b) [redacted] further stated that when the temperatures were out of range, the staff should have notified the U. S. FOIA [redacted] or a supervisor and the dish machines should have been serviced. The U. S. FOIA (b) [redacted] added that it was important that the dish machines were at the correct temperatures to properly clean the dishes, that chemicals should not be stored directly on the floor and should be stored in a designated area, and that it was important to clean the can opener after each use for sanitary reasons. A review of the facility's "Equipment sanitation" policy undated, revealed that all food service equipment shall be cleaned and sanitized after each use in accordance with manufacture specifications and established sanitation procedures. A review of the facility's "Chemical Storage" policy undated, revealed all chemicals will be stored in a safe manner and items will be stored 6 inches from the floor. A review of the facility's "Dish and Pot Machine Temperature Monitoring" policy undated, included dish machine and pot machine operating temperatures shall be monitored and documented to ensure equipment is functioning and providing effective cleaning and sanitation. NJAC 8:39-17.2(g)	F0812		07/13/2026
F0640 SS = D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility:	F0640	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? A discharge MDS assessment was completed and transmitted for resident #77 2. How will you identify other residents having the potential to be affected by the deficient practice and	07/13/2026

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F0640 SS = D	Continued from page 4 (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS.	F0640	Continued from page 4 what corrective actions will be taken? All residents had the potential to be affected by the deficient practice An audit was completed from January 2025 through May 2026 to include all residents during the time period for all required MDS assessments The results of the audit didn't find any other missing required MDS assessments The Assistant Director of Nursing education the MDS team on the importance of completing all required MDS assessments timely 3. What measures will be put into place or what system changes will you make to ensure that the deficient practice does not recur? The MDS coordinator will audit all required MDS assessments weekly for three months to ensure that all required MDS assessments have been completed and transmitted for all residents 4. How will the corrective action be monitored to ensure that the deficient practice does not recur (QA)? Who will be responsible? The findings of the weekly MDS resident assessments audits, will be reported to the QAPI committee monthly by the MDS coordinator for a minimum of three months	07/13/2026

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F0640 SS = D	Continued from page 5 This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, it was determined that the facility failed to complete and transmit a Minimum Data Set (MDS) discharge tracking record in accordance with federal guidelines. This deficient practice was identified for 1 of 1 resident reviewed for resident assessment (Resident #77). This deficient practice was evidenced by: Reference A MDS is a comprehensive tool that is a federally mandated process for clinical assessment of all residents that must be completed and transmitted to the Quality Measure System. The facility must electronically transmit the MDS within 14 days of the assessment being completed. On 6/4/26 at 1:10 PM, the surveyor reviewed Resident #77's electronic medical record. The record included that the resident was discharged [redacted] on [redacted] but that there was no discharge tracking record completed for the resident's discharge date. On 6/5/26 at 9:04 AM, the surveyor interviewed the U. S. FOIA (b) (2). The U. S. FOIA (b) (2) confirmed that the discharge tracking record was not completed or transmitted for Resident #77. She stated it should have been completed and transmitted within 14 days of the resident's discharge. On 6/8/26 at 9:14 AM, the surveyor interviewed the [redacted] in the presence of the survey team. The [redacted] stated that the discharge MDS should be completed within 14 days of discharge. The [redacted] stated that it was important that the Discharge MDS was completed in a timely manner because it was a requirement for reimbursement and quality measures. A review of the facility's "MDS Assessment" policy dated October 2025, revealed that the MDS clinical assessment was completed on all residents at the appropriate intervals as required by the federal government. Assessments were completed upon admission, readmission, discharge, quarterly, annually and when a resident experienced a significant change in condition.	F0640		07/13/2026

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F0640 SS = D	Continued from page 6 NJAC 8:39-11.2	F0640		07/13/2026
F0656 SS = D	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. (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	F0656	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? The comprehensive care plan for resident #11 was reviewed and updated to include the use of an NJ Ex Order 26.4(b)(1) 2. How will you identify other residents having the potential to be affected by the deficient practice and what corrective actions will be taken? A report was run to identify any resident that utilizes an orthopedic device The comprehensive care plans of any resident that uses an orthopedic device were reviewed and updated as needed to include the use of an orthopedic device The Assistant Director of Nursing educated the IDT team on care planning 3. What measures will be put into place or what system changes will you make to ensure that the deficient practice does not recur? The Unit Manager for the Skilled Nursing Unit will run a report weekly for any residents that are using an orthopedic device The Unit Manager for the Skilled Nursing Unit will audit the care plans of residents utilizing an orthopedic device weekly for one month and then monthly for two months, to ensure that the use of the device is included in the care plan 4. How will the corrective action be monitored to ensure that the deficient practice does not recur (QA)? Who will be responsible? The Unit Manager will report the findings of the	07/13/2026

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F0656 SS = D	Continued from page 7 plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and review of other facility documentation, it was determined that the facility failed to develop a comprehensive care plan for 1 of 2 residents (Resident #11) reviewed NJ Ex Order 26.4(b)(1). This deficient practice was evidenced by the following: On 6/04/26 at 10:15 AM, the surveyor observed Resident #11 lying in bed. The resident's [redacted] was [redacted] without a [redacted] in place. On 6/05/26 at 12:46 PM, the surveyor observed Resident #11 lying in bed. The resident's [redacted] was [redacted] without a [redacted] in place. The surveyor reviewed the electronic medical record (EMR) for Resident #11. A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included, but were not limited to, [redacted] A review of the Order Summary Report, dated as of [redacted] included a physician's order for a [redacted] to be applied to the [redacted] every morning and be removed every night at bedtime with an order date of [redacted] A review of Nursing Progress Notes, dated [redacted], indicated that nursing staff were aware that an order had been placed for a [redacted] to be applied to the [redacted] every morning and removed every night at bedtime.	F0656	Continued from page 7 audits to the QAPI team monthly for a minimum of three months	07/13/2026

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F0656 SS = D	Continued from page 8 A review of the NJ Ex Order 26, 4B1 Summary, dated NJ Ex Order 26, included the recommendation that a NJ Ex Order 26, 4B1 should have been NJ Ex Order throughout the day and been NJ Ex Order 26,4B at night, or NJ Ex Order for whatever duration would have been tolerated by Resident #11. A review of the NJ Ex Order 26, 4B1 Treatment Administration Record (TAR) indicated that Resident #11 had frequently refused to NJ Ex Order 26, 4B1. A review of the individual comprehensive care plan did not include resident-specific instructions for the use of a physician ordered NJ Ex Order 26, 4B1 to the resident's NJ Ex Order 26, 4B. On 6/08/26 at 9:44 AM, the surveyor interviewed Licensed Practical Nurse (LPN) #1 who stated that it was the responsibility of nursing staff to ensure that NJ Ex Order 26, 4B1 were applied to residents as they were ordered. On 6/08/26 at 9:48 AM, the surveyor interviewed Registered Nurse (RN) #1 who stated that Resident #11 had an order for a NJ Ex Order 26, 4B1. RN #1 also stated that Resident #11 had often refused to NJ Ex Order their NJ Ex Order 26, 4B1 On 6/08/26 at 9:52 AM, the surveyor interviewed the U. S. FOIA (b) (2) who stated that a resident-specific care plan for the use of a physician's ordered NJ Ex Order 26, 4B1 should have been completed by either therapy staff, nursing staff, or nursing leadership. A review of the facility's "Orthopedic Devices" policy revised October 2025, included the following: Orthopedic devices would be utilized, monitored, and maintained in accordance with physician's orders, therapy recommendations, and resident-specific care plans to ensure safe and effective use. Resident care plans and physician orders would specify (a.) the purpose of the device, (b.) duration of use, (c.) frequency of application and removal, (d.) required comfort checks, (e.) skin assessment requirements, and (f.) any adjustments, modifications, or re-evaluations as needed.	F0656		07/13/2026

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F0656 SS = D	Continued from page 9 NJAC 8:39 - 27.1(a)	F0656		07/13/2026

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F0000	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted on 07/14/2026 in relation to the 06/12/2026 Recertification survey. The facility was found to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.	F0000		

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.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315499	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - LIONS GATE** B. WING	(X3) DATE SURVEY COMPLETED **06/12/2026**

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
K0000 Bldg. 01	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations from 6/11/2026 to 6/12/2026 and the facility and was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy. Lions Gate is a Type II protected construction building. The facility is divided into 12 smoke zones. The 500 kw exterior diesel generator approximately 100% of the building. The LTC and Rehabilitation areas are served by wet sprinkler systems. There are 6 fire hydrants on the property that the facility maintains and inspects. The facility has 110 licensed beds and had a census of 90 residents at the time of survey.	K0000		07/01/2026
K0324 SS = F Bldg. 01	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under	K0324	Education has been updated to reflect actual date the training was conducted and has been uploaded under attachments. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? No residents were found to have been affected by the deficient practice How will you identify other residents having the potential to be affected by the deficient practice and what corrective actions will be taken? All residents had the potential to be affected by the	07/17/2026

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 **01 - LIONS GATE** B. WING	(X3) DATE SURVEY COMPLETED **06/12/2026**

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K0324 SS = F Bldg. 01	Continued from page 1 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This STANDARD is NOT MET as evidenced by: Based on observations and interviews from 06/12/26 in the presence of the U. S. FOIA (b) (2) [redacted], it was determined that the facility failed to ensure that cooking equipment was maintained in accordance with NFPA 101:2012 Edition, Sections 9.2.3, NFPA 17 A :2009 Edition, Section 4.3.1.5, and NFPA 96. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation on 06/12/26 at 8:45 AM, revealed that five (5) of the suppression system spray nozzles on the two (2) kitchen hoods were not provided with a cap or other suitable device to prevent the entrance of grease vapors, moisture, or other foreign materials into the piping. An observation at 8:48 AM, revealed the suppression system shared between the Meat and Dairy hood had two pieces of the suppression system nozzles resting on a half wall between the two sides. The nozzles were not properly placed to protect the equipment below them. During an interview at 8:50 AM, the [redacted] confirmed the observations. The [redacted] stated that kitchen equipment had recently been rearranged and the nozzles had not yet been placed in their permanent position. The [redacted] stated that he would have the suppression system corrected immediately. The facility's [redacted] was notified of the deficient practice during the Life Safety Code exit conference on 06/12/26 at 12:45 PM. N.J.A.C 8:39-31.1(c), 31.2 (e) NFPA 96, 17A	K0324	Continued from page 1 deficient practice The company that services the kitchen suppression system was out and replaced the caps missing from the five nozzles The part of the suppression system that was resting on the wall has been moved and placed in the proper position by the company that services the suppression system What measures will be put into place or what system changes will you make to ensure that the deficient practice does not recur? When equipment is moved in the kitchen that impacts the placement of the suppression system, the company that services the kitchen suppression system will be called to provide service The Director of Maintenance educated the kitchen and maintenance staff on the importance of the fire suppression system being installed properly with all required parts A Visual inspection of the kitchen suppression system will be conducted daily by the closing supervisor of the dining department for three months How will the corrective action be monitored to ensure that the deficient practice does not recur (QA)? Who will be responsible? The Assistant Director of Dining will conduct monthly audits of the visual inspections of the kitchen suppression system The Assistant Director of Dining will report the findings of the monthly audits to the QAPI committee monthly for a minimum of three months	07/17/2026
K0321 SS = E Bldg. 01	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure	K0321	Training and education has been updated to include the full date the training was conducted and has been uploaded to attachments. What corrective actions will be accomplished for	07/17/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315499	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - LIONS GATE B. WING	(X3) DATE SURVEY COMPLETED 06/12/2026

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K0321 SS = E Bldg. 01	Continued from page 2 Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This STANDARD is NOT MET as evidenced by: Based on observations and interviews on 06/11/26 in the presence of the U. S. FOIA (b) (2) [redacted], it was determined that the facility failed to ensure that that hazardous areas were separated from other spaces by smoke resisting partitions and doors in accordance with NFPA 101:2012 Edition, Sections 8.4 and 19.3.5.9. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation on 06/11/26 at 11:33 AM, revealed the first-floor Old Spa Room which was over 100 square feet and was being used to store combustible	K0321	Continued from page 2 those residents found to have been affected by the deficient practice? No residents were found to have been affected by the deficient practice How will you identify other residents having the potential to be affected by the deficient practice and what corrective actions will be taken? All residents had the potential to be affected by the deficient practice The medical glove was removed from the catch opening of the spa door What measures will be put into place or what system changes will you make to ensure that the deficient practice does not recur? All staff working on the first floor of skilled nursing have been re-educated by the Director of Nursing, not to push gloves or other objects into the catch opening of doors The Director of Maintenance educated the environmental services and maintenance staff on the importance of corridor doors closing and latching A closer has been added to the spa door so it will self-close The maintenance technician will check all corridor doors daily to ensure they close and latch How will the corrective action be monitored to ensure that the deficient practice does not recur (QA)? Who will be responsible? The Director of Nursing will perform weekly rounds for three months, to check that there aren't objects in the catch opening of the door to the spa room	07/17/2026

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K0321 SS = E Bldg. 01	Continued from page 3 materials. The door did not have a closer and would not self-close and latch when tested by the [redacted]. When pulled closed by the [redacted] the door could not latch due to a medical glove having been pushed into the catch opening. During an interview at 11:34 AM, the [redacted] confirmed the observations. The facility's [redacted] was notified of the deficient practice during the Life Safety Code exit conference on 06/12/26 at 12:45 PM. N.J.A.C 8:39-31.2 (e)	K0321	Continued from page 3 The Director of Nursing will audit the weekly rounds monthly and present the results to the QAPI team monthly for three months The Director of Maintenance will audit the daily door checks monthly The Director of Maintenance will report the findings of the monthly audits to the QAPI committee monthly for a minimum of three months	07/17/2026
K0353 SS = E Bldg. 01	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on observations and interviews on 06/12/26, in the presence of the [redacted], it was determined that the facility failed to ensure that the automatic sprinkler system was inspected, tested, and maintained (ITM) in accordance with NFPA 101:2012 Edition, Sections 9.7.5, 9.7.7, 9.7.8 and NFPA 25:2011	K0353	Education has been updated to reflect the full date the training was conducted and has been uploaded under attachments. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? No residents were found to have been affected by the deficient practice How will you identify other residents having the potential to be affected by the deficient practice and what corrective actions will be taken? All residents had the potential to be affected by the deficient practice The company that services the sprinkler system came out and cleaned the two sprinklers above the commercial dryers The company that services the commercial dryers came out and cleaned the filter grate behind the commercial dryers What measures will be put into place or what system changes will you make to ensure that the deficient practice does not recur?	07/17/2026

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K0353 SS = E Bldg. 01	Continued from page 4 Edition, Chapter 5. This deficient practice had the potential to affect all residents, and was evidenced by the following: An observation at 8:42 AM, revealed two (2) of 2 sprinklers above the commercial dryers covered in foreign matter. An observation at 8:43 AM, revealed the filter grate behind the commercial dryers, partially blocked by foreign matter. During an interview at 8:43 AM, the U. S. FOIA (b) (2) confirmed the observations. The facility's U. S. FOIA (b) (2) was notified of the deficient practice during the Life Safety Code exit conference on 06/12/26 at 12:45 PM. NJAC 8:39-31.2(e) NFPA 25	K0353	Continued from page 4 The company that services the sprinkler system will clean the two sprinklers above the commercial dryers quarterly The company that services the commercial dryers will clean the filter grate behind the commercial dryers quarterly The Director of Maintenance educated the laundry and maintenance staff on the importance of safety equipment and ventilation systems being free of dirt or dust accumulation How will the corrective action be monitored to ensure that the deficient practice does not recur (QA)? Who will be responsible? The Director of Maintenance will audit the quarterly inspection reports of the sprinkler system to ensure the two sprinkler heads above the commercial dryers have been cleaned The Director of Maintenance will audit the quarterly cleanings of the commercial dryers to ensure the filter grate behind the commercial dryers has been cleaned The Director of Maintenance will report the audit findings to the QAPI committee monthly for a twelve-month period	07/17/2026
K0712 SS = E Bldg. 01	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7	K0712	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? No residents were found to have been affected by the deficient practice How will you identify other residents having the potential to be affected by the deficient practice and what corrective actions will be taken? All residents had the potential to be affected by the	07/20/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315499	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - LIONS GATE** B. WING	(X3) DATE SURVEY COMPLETED **06/12/2026**

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K0712 SS = E Bldg. 01	Continued from page 5 This STANDARD is NOT MET as evidenced by: Based on documentation review on 06/12/26 in the presence of th U. S. FOIA (b) (2) [redacted], it was determined that the facility failed to conduct in-house fire drills at least each shift, every quarter (every 3 months) in accordance with NFPA 101: 2012 Edition, Sections 19.7.1.4 through 19.7.1.7. This deficient practice had the potential to affect all residents in the facility and was evidenced by the following: A documentation review at 9:30 AM, revealed the following fire drills: 5/26/26 – 3-11PM – 6:20PM 4/24/26 – 7-3PM – 2:45PM 3/28/26 – 3-11PM – 5:41PM 2/28/26 – 3-11 PM – 4:10PM 1/12/26 – 7-3PM – 2:02PM 12/30/25 – 11-7AM – 12:35AM 11/20/25 – 3-11PM – 9:52PM 10/28/25 – 3-11PM – 10:09PM 9/27/25 – 11-7AM – 6:13AM 8/16/25 – 7-3PM – 10:40AM 7/28/25 - 3-11PM – 3:30PM 6/25/25 – 11-7AM – 6:19AM 5/12/25 – 7-3PM – 9:34AM The facility failed to perform fire drills one per shift every quarter throughout a 13 month look back. The months of April and May both had drills conducted on the 3pm - 11pm shift as did October and November. The facility's U. S. FOIA (b) (2) was notified of the deficient practice during the Life Safety Code exit conference on 06/12/26 at 12:45 PM. N.J.A.C 8:39-31.2 (e)	K0712	Continued from page 5 deficient practice A fire drill was conducted in skilled nursing on the 11-7 shift on June 26, 2026 What measures will be put into place or what system changes will you make to ensure that the deficient practice does not recur? Our community is a CCRC, and our fire system is one system. Drills are rotated between the Assisted Living and the Nursing Home, however, when the fire alarm is activated, it alarms throughout the entire community. Staff from all areas of the community respond to all drills, not just drills initiated in their area As a community we will not continue to rotate where the fire drills are initiated The Assistant Director of Maintenance educated the maintenance and environmental services staff on the importance of conducting fire drills according to regulations Each quarter, a drill will be initiated in both the Nursing Home and the Assisted Living on each shift How will the corrective action be monitored to ensure that the deficient practice does not recur (QA)? Who will be responsible? Each quarter, the Director of Maintenance will audit the fire drill reports to confirm a drill was initiated in the Nursing home on each shift The Director of Maintenance will report the findings of the quarterly audit to the QAPI committee monthly for a twelve-month period	07/20/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315499	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - LIONS GATE B. WING	(X3) DATE SURVEY COMPLETED 06/12/2026

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K0920 SS = E Bldg. 01	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This STANDARD is NOT MET as evidenced by: Based on observations and interviews on 06/11/26 in the presence of the U. S. FOIA (b) (2) [redacted], it was determined that the facility failed to prohibit the use of extension cords beyond temporary installation, as a substitute for adequate wiring, exceeding 75% of the capacity, in accordance with NFPA 101: 2012, Sections 19.5, 19.5.1,9.1 and 9.1.2, NFPA 70: 2011 Edition, Sections 400.8 and 590.3 (D), NFPA 99: 2012 Edition, Sections 10.2.3.6 and 10.2.4. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 9:56 AM, revealed a microwave oven plugged into a power strip within a closet in the Physical Therapy Gym. During an interview at 9:56 AM, the [redacted] confirmed the observation. An observation at 9:58 AM, revealed a refrigerator and a microwave oven plugged into a power strip within the U. S. FOIA (b) (2) office. During an interview at 9:59 AM, the [redacted] confirmed the observation. An observation at 11:20 AM, within the U. S. FOIA (b) (2) [redacted]) Office revealed an orange extension cord plugged into the wall and then into a power strip with a second power strip plugged into the first power strip. The	K0920	What corrective actions will be accomplished for those residents found to have been affected by the deficient practice? No residents were found to have been affected by the deficient practice 2. How will you identify other residents having the potential to be affected by the deficient practice and what corrective actions will be taken? All residents had the potential to be affected by the deficient practice The microwave in the physical therapy gym has been removed from the power strip and plugged directly into the wall outlet The refrigerator in the admission coordinator office have been removed from the power strip and plugged directly into the wall outlet. The microwave has been removed from the office. The microwave and refrigerator in the mds/unit manager office have been removed from the power strip and plugged directly into the wall outlet. The toaster has been removed from the office. 3. What measures will be put into place or what system changes will you make to ensure that the deficient practice does not recur? Staff that have appliances in their offices have been re-educated by the Director of Maintenance on the proper procedure for plugging in an appliance The Director of Maintenance will conduct weekly rounds for one month and then bi-weekly rounds for two months to all offices, to ensure no appliances are plugged into power strips and are plugged directly into the wall outlet 4. How will the corrective action be monitored to ensure that the deficient practice does not recur (QA)? Who will be responsible?	07/13/2026

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K0920 SS = E Bldg. 01	Continued from page 7 power strips had a microwave oven, refrigerator, toaster, and a computer plugged into them. During an interview at 11:22 AM, the [redacted] confirmed the observation. The facility's [redacted] was notified of the deficient practice during the Life Safety Code exit conference on 06/12/26 at 12:45 PM. NJAC 8:39-31.2(e)NFPA 70, NFPA 99	K0920	Continued from page 7 The Director of Maintenance will audit his rounds monthly and report his audit findings to the QAPI committee monthly for a minimum of three months	07/13/2026

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E0000	Initial Comments An emergency Preparedness Survey was conducted by the New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations from 6/11/2026 through 6/12/2026. Lions Gate was found to be in compliance with Medicare/Medicaid at 42 CFR, Subpart 483.73, Emergency Preparedness.	E0000		06/30/2026

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

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K0000 Bldg. 01	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted on 07/31/2026 in relation to the 06/12/2026 Life Safety Code survey. The facility was found to be in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy.	K0000		

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 07/31/2026

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
E0000	Initial Comments An offsite/desk review of the facility's Plan of Correction was conducted on 07/31/2026 in relation to the 06/12/2026 Emergency Preparedness survey. The facility was found to be in compliance with the requirement for participation in Medicare/Medicaid at 42 CFR, Subpart 483.73, Emergency Preparedness.	E0000		

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