STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315174	A. Building B. Wing	12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Deptford Center for Rehabilitation and Healthcare	1511 Clements Bridge Rd Deptford, NJ 08096

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on interview and record review, it was determined that the facility failed to ensure that a resident's physician ordered medication was signed as administrated at the time of administration in accordance with professional standard of practice. This deficient practice was identified for 1 of 9 residents reviewed for standards of practice (Resident #7).The evidenced was as followed: Reference: The practice of nursing as a Licensed Practical Nurse is defined as performing tasks, and responsibilities within the framework of case finding, reinforcing the patient and family teaching program through health teaching, health counseling, and provision of supportive and restorative care, under the direction of a Registered Nurse, or otherwise legally authorized Physician or Dentist. A review of the admission Record (AR) revealed that Resident #7 was admitted to the facility with diagnoses that included but were not limited to; acute right heart failure, diabetes, major depressive disorder, and muscle weakness. A review of Resident #7's quarterly Minimum Data Set (MDS), an assessment tool dated 8/27/25, revealed that the resident had a Brief Interview Mental Status (BIMS) score of 15 out of 15, indicating that the resident's cognition was intact. A review of Resident #7's September 2025 Medication Administration Record (MAR), located in the electronic medical record, included a physician's order (PO) dated 3/17/25, for levothyroxine sodium oral tablet 88 micrograms (mcg); give one tablet by mouth in the morning for hypothyroid. The MAR was blank on 9/19/25, for the administration. On 10/8/25 at 1:00 PM the surveyor requested from the Director of Nursing (DON) a copy of Resident #7's September 2025 MAR. A review of Resident #7's September 2025 MAR provided by the DON revealed that the levothyroxine was signed as administered for the 9/19/25 at 6:00 AM dose. On 10/9/25 at 1:15 PM, the surveyor requested from the DON a copy of Resident #7's Medication Admin Audit Report for September 2025. On 10/9/25 at 1:22 PM, the DON provided Resident #7's September 2025 Medication Admin Audit Report. At that time, the surveyor reviewed the report, which revealed Resident #7's scheduled 9/19/25 at 6:00AM, levothyroxine dose was signed as administered on 10/9/25 at 1:06 PM. On 9/8/25 at 1:31 PM, the DON reviewed Resident #7's Medication Admin Audit Report and confirmed the 9/19/25, dose of the levothyroxine was signed as administered on 10/9/25 at 1:06 PM. The DON stated that medication administration should be documented immediately after the medication was administered. The DON further stated that her expectation was that the nurse signed for the administration of the medication at the time of administration. On 10/8/25 at 1:46 PM, the surveyor interviewed the License Practical Nurse (LPN), who was assigned to administer Resident #7's levothyroxine on 9/19/25 at 6:00 AM. The LPN stated that she administered the medication, but she forgot to sign the MAR. A review of the facility's policy Medication Administration with a revision date of 12/2019, revealed under Procedure number 12., The individual administrating the medication must initial the resident's MAR [Medication Administration Record] on the appropriate line after giving each medication and before administering the next ones. NJAC8:39-11.2(b)

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.

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