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	08/18/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, it was determined that the facility failed to maintain kitchen equipment in a clean and sanitary manner as evidenced by the following: On 8/8/25 at 9:58 AM, in the presence of the Food Service Director (FSD), the surveyor observed the following: 1. The microwave had multicolored dried stuck on debris on the interior ceiling of the unit. The FSD acknowledge it was not properly cleaned according to facility policy. 2. The convection ovens were soiled with baked on brown coloring on the glass doors making them opaque and not transparent. There were baked on debris on the interior corners of the units. The FSD acknowledged and stated, it was not cleaned according to facility policy. 3. The six-burner stove top and oven were not clean. The interior of the oven had food sediment and build up on the interior door. The catch tray that was lined with foil had burnt liquid, and food debris covering the entire tray and foil that was peeling. The FSD acknowledged and stated, it was not cleaned according to facility policy. 4. The griddle top and the splash guard surround had crusted, hardened, and scrapeable black debris. The FSD acknowledged and stated, it was not cleaned according to facility policy. 5. The fryer had food debris on the ledge of the oil well and the oil was dark brown in color during the ladle check. The FSD acknowledged and stated, that it was not cleaned according to facility policy. 6. The can opener blade had a metal chip on right side and food debris that were brown in color and sticky located on shaft near blade and holder. The FSD stated, the blade had not been changed since she started at the facility and there was not a maintenance log in place on when to replace the blade or a cleaning log for the can opener. The FSD acknowledged that it was not cleaned according to facility policy. On 8/8/25 at 10:45 AM, the surveyor interviewed the FSD, who acknowledged the surveyors finding and stated the equipment should have been cleaned and maintained in a sanitized way to prevent food borne illness and contamination for safety of the residents and staff. On 8/14/25 at 11:43 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA), who acknowledged the surveyors concerns after reviewing the pictures of the kitchen equipment. The LNHA stated the equipment should be cleaned and maintained to prevent food borne illness, contamination, or injury. He further stated it should be cleaned to ensure the safety of the residents and staff. On 8/18/25 at 9:47 AM, the survey team met with the LNHA, Assistant LNHA, Regional Clinical Director (RCD), and the Director of Nursing (DON), who all acknowledged the surveyor's concerns. No additional information was provided. A review of the facility's, Food and Nutrition Services, dated, January 2023, included policy statement.The food service area shall be maintained in a clean and sanitary manner.All kitchen areas, food service areas, and dining areas shall be kept clean, free from debris and protected from rodents, roaches, flies and other insects. The FSD will be responsible for scheduling staff for regular cleaning of the kitchen. NJAC 8:39-17.2(g)

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

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	08/18/2025

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 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, it was determined that the facility failed to ensure that all residents that maintained a Personal Needs Account (PNA) a.) received a written notification when approaching the limit that could jeopardize a resident's eligibility for Medicaid or Supplemental Security Income (SSI) and b.) funds and final accounting of those funds were conveyed within 30 days of the resident's discharge or death to the proper jurisdiction.This deficient practice was identified for 12 of 13 residents (Resident #6, #39, #80, #159, #173, #186, #239, #241, #243, #245, #248 and #249) reviewed for PNA and was evidenced by: 1.) On [DATE] at 12:00 PM, the Licensed Nursing Home Administrator (LNHA) provided the PNA balances as of [DATE]. A review of the facility's Trial Balance revealed 12 residents had balances that ranged from $1,964.18 to $39,870.91.On [DATE] at 10:48 AM, the surveyor interviewed the Regional Director of Finance (RDF) who stated that she was covering for the Finance Coordinator (FC) who was currently on vacation. The RDF stated that the quarterly PNA balance statements were sent out and that they informed the resident or the resident's representative that the balance was high. On [DATE] at 10:12 AM, the RDF and the surveyor reviewed the Resident Activity List, and the RDF confirmed it was for [DATE], which was the last quarterly and during the month of [DATE] the PNA statements were distributed.At that time, the surveyor and RDF then reviewed the Resident Statement Landscape which indicated the following:Resident #6 had an account balance of $7,014.28 as of [DATE]. The RDF stated that the resident had an overpayment that was returned [DATE] after surveyor inquiry. Resident #39 had an account balance of $2,254.28 as of [DATE]. The RDF stated that the resident's quarterly statement was mailed and emailed to the Office of Public Guardianship (OPG). Resident #80 had an account balance of $2,051.48 as of [DATE]. The RDF stated that the quarterly statements were left at the front desk for when the resident's representative stated they were coming to visit that month. Resident #159 had an account balance of $2,081.13 as of [DATE]. The RDF stated that the quarterly statements were mailed to the resident's representative. Resident #173 had an account balance of $3,092.55 as of [DATE]. The RDF stated that the resident had an overpayment that was returned [DATE] after surveyor inquiry. Resident #186 had an account balance of $2,196.42 as of [DATE]. The RDF stated that the quarterly statements were mailed to the resident's representative. On [DATE] at 10:23 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) who stated that the facility sent out the quarterly statement but not a written notification letter. He stated he just found out that there was a letter that could be sent out. On [DATE] at 11:51 AM, during a follow-up interview the RDF stated she was not aware of any letter that was sent out to the resident to inform them they were approaching the limit that could jeopardize a resident's eligibility for Medicaid or SSI until recently. When asked how the resident or the representative would know, she stated they received their quarterly statements and that they were aware of the risk during enrollment that they were not to go over $2,000.00. The RDF then stated that they did encourage residents to spend down their monies. 2.) On [DATE] at 9:55 AM, the surveyor interviewed the RDF who stated that after a resident was discharged or deceased , within 30 to 60 days the monies should be returned to the appropriate party. She stated that sometimes it could take longer depending on the situation but generally the process to return the funds should be started right away. On [DATE] at 11:02 AM, the surveyor reviewed the electronic medical records (EMR) census which reflected the following: Resident #239 expired on [DATE]. Resident #241 expired on [DATE].Resident #243 was discharged on [DATE].Resident #245 was discharged on [DATE]. Resident #248 was discharged [DATE]. Resident #249 expired on [DATE]. On [DATE] at 10:12 AM, the RDF and the surveyor reviewed the Resident Activity List, and the RDF confirmed it was for [DATE], which was the last quarterly. At that time, the surveyor and RDF then reviewed the Resident Activity List and the Resident Statement Landscape as of [DATE] which indicated the following:Resident #239 had an account balance of (continued on next page)

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	08/18/2025

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 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	$2,227.96 with interest being paid, was deceased , and the funds were not returned to Medicaid within 30 days. Resident #241 had an account balance of $1,964.18 with interest being paid, was deceased , and the funds were not returned to Medicaid within 30 days. Resident #243 had an account balance of $39,870.90 with interest being paid, was discharged but then expired, and the funds were not returned within 30 days. The RDF stated she was waiting on the PR-1 form (used to determine how much of a Medicaid recipient's income is available to offset the cost of their long-term care in a nursing facility) and confirmation on what to do with the funds from [name redacted] county. Resident #245 had an account balance of $2,465.87, was discharged to the hospital, later transferred to another facility, and the funds were not transferred. A review of the Resident Activity List indicated the resident's representative who worked at the facility received the quarterly statements. Resident #248 had an account balance of $16,327.70 with interest being paid, was discharged , and the funds were not returned to the State.Resident #249 had an account balance of $4,882.23 with interest being paid, was deceased , and the funds were not returned to Medicaid. At that time, the RDF stated she would have to follow up with the FD on why the funds were just now being returned. She acknowledged the funds should have been returned prior to surveyor inquiry. On [DATE] at 10:20 AM, in the presence of the Assistant LNHA (ALNHA) and the Corporate Support (CS) the surveyor interviewed the LNHA who stated they tried to contact the resident or representative within 30 days of the funds, but not all residents had families or guardianship. On [DATE] at 9:49 AM, the LNHA and ALNHA acknowledged in the presence of the Director of Nursing (DON), the Regional Clinical Director (RCD) and the survey team that the written notification letter should have been sent out to the resident reaching the maximum amount and the monies should have been sent back within 30 days of the resident being discharged or deceased . A review of the facility's Resident Funds Account (RFA) policy date revised [DATE], included, 11. The facility will notify residents who receive Medicaid benefits when their Resident Funds Account reaches $200.00 less than the Medicaid/SSI resource limit and will explain to the resident the criteria under which the resident may lost eligibility for Medicaid/SSI. 12. Upon discharge of a resident: a. the facility shall refund any balance of resident funds held by the facility to the resident or authorized representative.not to exceed thirty (30) days from the date of discharge 13. Upon resident death funds shall be conveyed.within 30 days. NJAC 8:39-9.5

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	08/18/2025

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to ensure a low-air-loss mattress was operating and set according to the resident's weight, as per a physician's order for a resident previously identified as being at risk for impaired skin integrity.This deficient practice was identified for 1 of 4 residents (Resident #7) reviewed for positioning and mobility, and was evidenced by the following:On 8/8/2025 at 10:46 AM, the surveyor observed Resident #7 lying in bed awake. The mattress was noted to be inflated; however, the air loss mattress (a mattress used to prevent and treat pressure ulcers) was not on at that time. There was a piece of tape on the machine, with weight 235 pounds (lbs), written on it.On 8/13/2025 at 11:08 AM, the surveyor conducted a follow-up visit to the resident's room. Resident #7 was observed lying in bed and the air mattress was set to 250 lbs.A review of the admission Record, an admission summary, revealed the resident had diagnoses which included, but were not limited to: obesity, edema, and muscle weakness.A review of the resident's most recent comprehensive Minimum Data Set (MDS), an assessment tool, dated 7/17/2025, included the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident's cognition was intact.A review of the resident's individual comprehensive care plan (ICCP) included a focus area, dated 1/18/2022, included that the resident was at risk for impaired skin integrity related to fragile skin. The interventions included: Low air loss mattress to bed and check air mattress for functioning every shift.A review of the Order Summary Report (OSR), included the following physician orders (PO):A PO, dated 4/10/2025, for Low air loss mattress and to check the setting closest to resident's current weight, and check the mattress functionality.A review of the August 2025 Medication Administration Record (MAR) and Treatment Administration Record (TAR) revealed that the low air mattress was signed off by the nurse as administered on 8/8/2025 and 8/13/2025.A review of the weights in the resident's electronic health record (EHR) indicated that on 8/12/2025, the resident weighed 193 lbs.On 8/13/2025 at 12:05 PM, the surveyor interviewed Licensed Practical Nurse (LPN) #2, who stated that the settings on the low air loss mattress should be checked daily to ensure that it was on the correct setting. She further noted that if it was not set correctly, it can cause an injury to the resident or worsen a pre-existing injury.On 8/13/2025 at 12:15 PM, the surveyor interviewed Licensed Practical Nurse/Unit Manager (LPN/UM) #3, who stated that the low air loss mattress should be functioning and set according to the resident's weight. She further noted that the setting should not go beyond the resident's weight, and on every shift, the Certified Nurse Aides (CNAs) and LPNs should ensure that it was working and functioning.At that time, the surveyor was accompanied by LPN/UM #3 to the resident's room. The LPN/UM confirmed that the setting was on 250 lbs and should have been set to 200 lbs.On 8/13/2025 at 1:07 PM, the surveyor interviewed the Director of Nursing (DON), who stated that the PO specified the air loss mattress should be set to the number closest to the resident's weight. She further noted that the nurses should follow the care plan and the physician's orders, and ensure that it was turned on and at the correct settingA review of the facility's Support Surfaces- Air Mattress dated February 2019 included, It is the policy of the facility to provide an environment of care that promotes the highest quality of care and comfort for residents. This includes the treatment and prevention of pressures with the use of support surfaces. NJAC 8:39-27.1(a)

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	08/18/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to ensure an accurate account of the administration and documentation of controlled medications.This deficient practice was identified for 1 of 3 nurses on 1 of 8 nursing units (2 D) reviewed during the medication administration and storage observation and was evidenced by the following: On 8/12/25 at 8:57 AM, the surveyor observed Licensed Practical Nurse (LPN) #1 administer six (6) medications to Resident #128 during the medication administration observation. When finished, the surveyor requested to review the Shift Count narcotic inventory log. The surveyor reviewed the Shift Count for the 8/12/25 for the 7 AM - 3 PM shift and noted that the designated area for Is Count Correct and EDK [Emergency Drug Kit] Sealed were not answered with a Yes or No response and both areas were blank. There were two illegible signatures in the area designated for the nurse's signature that was coming on duty and the nurse's signature for going off duty. The surveyor asked LPN #1 if she signed the Shift Count to confirm accuracy of the controlled medications in the cart prior to receipt at shift change? LPN #1 stated that she did not sign the Shift Count because the 11 PM -7 AM nurse had the book signing out her medications, so she did not sign the Shift Count. LPN #1 further stated that the narcotic count was done and there were no discrepancies. At that time, the surveyor requested to view and count the full controlled medication inventory with LPN #1. LPN #1 then proceeded to remove the bingo card (medication dosing system with multiple doses of a medication that are sealed separately in a bubble pack on a card with foil backing) of Clonazepam 0.25 milligrams (mg) (used to treat panic disorder/seizures) tablets and the Declining Inventory Sheet (DIS) indicated that there were 21 tablets remaining. Upon inspection of the bingo cards, there were only 20 tablets of Clonazepam 0.25 mg remained. When interviewed, LPN #1 stated that she administered the medication to Resident #99 at 8:00 AM, but she had not signed out the dosage on the DIS because the 11-7 nurse retained the book to sign out the controlled medications that she had administered during the 11-7 shift. LPN #1 stated that it was important to sign the DIS at the time the controlled medication was removed from the bingo card so that you did not miscount and there was proof of medication administration. LPN #1 then proceeded to count the inventory of Lyrica 75 mg tablets (used to treat nerve pain/seizures) and the DIS indicated that there were 55 tablets remaining, and upon inspection, only 54 tablets remained. LPN #1 stated that she administered the medication to Resident #152 but was unable to sign the book because the 11-7 nurse still had the book. LPN #1 then proceeded to count the inventory of Alprazolam 1 mg tablets (used to treat anxiety/panic disorder) and the DIS indicated that there were 58 tablets remaining, and upon inspection, only 57 tablets remained. LPN #1 stated that she could not sign the book because the 11-7 nurse still had the book. On 8/12/25 at 9:21 AM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM) #1 who stated that it was very important for both the oncoming and outgoing nurses to count the controlled medications together and sign the book upon completion to ensure that the narcotic count inventory was correct and there were no medication errors. LPN/UM #1 stated that as soon as the controlled medication was popped from the bingo card for administration the medication should be signed out on the DIS to ensure that there were no medication errors and that everything was accounted for. LPN/UM #1 stated that once the medication cart controlled medication inventory was counted, and the keys were handed off the nurse assuming the cart should have the book, keys and cart in their possession. LPN/UM #1 further stated that the book should not be retained by the nurse going off duty because you do not know what may be written in the book after you have counted the inventory. On 8/12/25 at 9:21 AM, the surveyor interviewed the Director of Nursing (DON) who stated that it was important to do the shift-to-shift count to ensure that the narcotic count was accurate. The DON stated that the incoming nurse should have notified the DON to obtain the book from the 11-7 nurse at shift change. The DON stated that the incoming nurse should (continued on next page)

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	08/18/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assume responsibility of the narcotic book because they were responsible for the narcotic inventory in the cart during their shift. The DON stated that she counted with the 11-7 nurse at 6:50 AM, and the cart was accurate, because LPN #1 was late. The DON further stated that it was LPN #1's fault for not signing out the medications at the time of administration because all of the nurses have been in-serviced for once you have given a narcotic, you are to sign it out immediately. The DON further stated that the nurse was required to sign the book the moment that the drug was popped out of the bingo card to ensure that the controlled medication was accounted for. On 8/18/25 at 9:36 AM, in the presence of the survey team, the Licensed Nursing Home Administrator (LNHA) was made aware of the concerns related to the lack of accountability with the controlled medication storage inventory and documentation. A review of the facility's Controlled Substance Management policy, created August 2022, included: .Separate records shall be maintained on all controlled substances in the form of a declining inventory record. Such records shall be accurately maintained and shall include a. the name of the resident. b. The name of the prescriber. c. The prescription numbers. d. The drug names. e. The form of the medication. f. The strength of the medication. g. The strength of the dose administered. H. The date and time of administration. i. The signature of the person administering the drug. Such records shall be reconciled by the incoming and outgoing nurse. Two nurses must count the remaining medication at each shift, and any handoff of narcotic keys All controlled substances shall be counted at the change of each shift by the incoming and outgoing nurse.Any discrepancy in the count of controlled substances is to be reported immediately to the Nursing Supervisor and a signed entry shall be recorded on the page where the discrepancy is found .The medication nurse is responsible for adhering to the procedures for ordering receiving, storing, administering and recording the administration of controlled drugs .NJAC 8:39-29.7(c), 29.2(d)

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	08/18/2025

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on interview, record review, and review of facility documents, it was determined that the facility failed to respond to comments/recommendations made by the Consultant Pharmacist (CP) in a timely manner. This deficient practice was identified for 1 of 5 residents (Resident #185) reviewed for Unnecessary Medications and was evidenced by the following:A review of Resident #185's Order Summary Report (OSR) revealed a Physician's Order (PO) dated 4/9/25, for Fludrocortisone Acetate (used to treat certain conditions in which the adrenal glands (a gland) cannot make enough hormones such as Addison's Disease) Oral Tablet 0.1 milligrams (mg) (Fludrocortisone Acetate) Give one (1) tablet by mouth one time a day for Syndromes. The surveyor reviewed the diagnoses listed on the resident's OSR which failed to include a medical diagnosis of syndromes. A review of Resident #185's August 2025 Medication Administration Record (MAR) revealed that the resident was ordered Fludrocortisone Acetate Oral Tablet 0.1 MG (Fludrocortisone Acetate) Give 1 tablet by mouth one time a day for Syndromes. The medication was scheduled to be administered between 7 AM - 10 AM and had been administered daily from 8/1/25 through 8/15/25. A review of the Consultant Pharmacist Inspection Report dated 5/2/25, revealed a recommendation to, Please clarify fludrocortisone ordered for syndromes. The Physician/Prescriber response: indicated a checked box which specified Agree with the recommendation and a signature was noted in the space provided for a Physician Signature.A review of a Consultant Pharmacist Consultation Note dated 6/6/25 at 12:30 PM revealed: Medication Regimen Reviewed. No recommendations made.A review of a Consultant Pharmacist Consultation Note dated 7/7/25 at 3:12 PM, revealed: Medication Regimen Reviewed. No recommendations made. On 8/14/25 at 11:44 AM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM) #2 who stated that the Consultant Pharmacist Recommendations were forwarded to her from the Director of Nursing (DON) via email. LPN/UM #2 stated that she then printed the recommendations out and gave them to the Nurse Practitioner (NP) for review. LPN/UM #2 stated that the NP would then sign the recommendation if she was in agreement and then we would carry out the recommendations and make the changes to the resident's medication orders at that time. The surveyor then presented LPN/UM #2 with the Consultant Pharmacist Inspection Report dated 5/2/25, in which the NP signed that he/she was in agreement with the CP recommendations to clarify fludrocortisone ordered for syndromes, and the recommendation was not addressed. LPN/UM #2 stated that the order should have been changed and returned to her by the next monthly review, as she did not believe that syndromes was an appropriate diagnosis for the medication. On 8/14/25 at 2:08 PM, the surveyor interviewed the facility supplier pharmacy Morning Supervisor who stated that fludrocortisone was originally ordered on 8/18/22 for an indication of syncope (temporary loss of consciousness caused by a fall in blood pressure). He further stated that when the medication was reordered on 4/9/25, the indication for syndromes was not clarified. On 8/14/25 at 2:30 PM, the surveyor interviewed the Assistant Director of Nursing (ADON) who stated that the facility changed Consultant Pharmacist Providers back in June of 2025. The ADON stated that the CP emailed the recommendation to her or the Director of Nursing (DON), and the recommendations were printed out and were then given to the physician for review to see if they agree or disagree. The ADON stated that if the physician did agree, then they updated the order, and we make sure that the recommendation was followed through. The ADON stated that the NP should have provided the correct diagnosis if she signed off in agreement. The ADON stated that the Unit Manager sat down and went over the recommendations with the NP and the recommendation should have been clarified at that time. On 8/18/25 at 9:36 AM, in the presence of the survey team, the Licensed Nursing Home Administrator (LNHA) was made aware of the concerns related to the failure of the facility to act upon the Consultant Pharmacist recommendations in a timely manner. A review of the facility's Medication Regimen Reviews (MRR) policy, revised November 2021), included: The Consultant Pharmacist (continued on next page)

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	08/18/2025

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reviews the medication regimen of each resident at least monthly The goal of the MRR is to promote positive outcomes while minimizing adverse consequences and potential risks associated with medication. An irregularity refers to the use of medication that is inconsistent with accepted pharmaceutical services standards of practice; is not supported by medical evidence; and/or impedes or interferes with achieving the intended outcomes of pharmaceutical services. It may also include the use of medication without indication, without adequate monitoring, in excessive doses, and or in the presence of adverse consequences.The attending physician documents in the medical record the irregularity has been reviewed and what (if any) action was taken to address it within 30 days of receiving the report. NJAC 8:39-29.3(a)1, b