STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315174	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/18/2025

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Deptford Center for Rehabilitation and Healthcare	**1511 CLEMENTS BRIDGE RD , DEPTFORD, New Jersey, 08096**

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F0000	INITIAL COMMENTS Complaint NJ #'s: 185130, 185190, 185196, 185679, 186128, 187780, and 187867; Intake ID: 2562036 and 2585578 Survey Dates: 8/8/25 to 8/18/25 Census: 224 Sample size: 35 + 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		09/28/2025
F0569 SS = E	Notice and Conveyance of Personal Funds CFR(s): 483.10(f)(10)(iv)(v) §483.10(f)(10)(iv) Notice of certain balances. The facility must notify each resident that receives Medicaid benefits- (A) When the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and (B) That, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. §483.10(f)(10)(v) Conveyance upon discharge, eviction, or death. Upon the discharge, eviction, or death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the resident, or in the case of death, the individual or probate jurisdiction administering the resident's estate, in accordance with State law.	F0569	Element #1 Written notifications were sent out to resident #6, #39, #80, #159, #173, or their representatives whose NJ Exec Order 26.4b1 were within NJ Exec Order 26.4b1. For NJ Exec Order 26.4 or discharged residents #186, #239, #241, #243, #245, #248, and #249:), final accountings were completed and funds were conveyed to the appropriate parties or probate jurisdictions in accordance with state law. Element #2 All residents have the potential to be affected by this deficient practice. On 9/1/25 a review of all residents' PNA accounts was conducted, and any resident who was discharged for 30 days or more had their money returned immediately. Additionally, on 9/3/25, all residents with a PNA account that was $200 from being over-resourced received a letter showing they are close to limit.	09/15/2025

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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F0569 SS = E	Continued from page 1 This REQUIREMENT is NOT MET as evidenced by: 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 8/8/25 at 12:00 PM, the US FOIA (b)(6) provided the PNA balances as of 8/8/25. A review of the facility's "Trial Balance" revealed 12 residents had balances that ranged from NJ Exec Order 26.4b1 On 8/13/25 at 10:48 AM, the surveyor interviewed the US FOIA (b)(6) who stated that she was covering for the US FOIA (b)(6)) who was currently on vacation. The US FOIA 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 NJ Ex Orc On 8/14/25 at 10:12 AM, the US. FOI and the surveyor reviewed the Resident Activity List, and the US FOIA confirmed it was for NJ Ex Order 26, which was the last quarterly and during the month of NJ Exec Order 26.4 the PNA statements were distributed. At that time, the surveyor and US FOIA then reviewed the Resident Statement Landscape which indicated the following: Resident #6 had an account balance of NJ Exec Order 26.4b as of NJ Exec Order 2 The US FOIA stated that the resident had an NJ Exec Order 26.4b1 that was returned NJ Exec Order after surveyor inquiry. Resident #39 had an account balance of NJ Exec Order 26.4b as of NJ Exec Orde The US FOIA stated that the resident's quarterly statement was mailed and emailed to the Office of Public Guardianship (OPG).	F0569	Continued from page 1 Element #3 Policy Update: The Resident Funds Account policy was revised on 9/1/2025 to include mandatory written notifications when balances approach the SSI limit. Staff Training: on 9/2/25 Finance and administrative staff were trained on the updated notification and conveyance procedures. Notification Template: A standardized letter was created for notifying residents/representatives of high balances. Element #4 Monthly audits of PNA balances will be conducted by the Finance Coordinator for 6 months. Quarterly compliance reviews will be presented to the Quality Assurance and Performance Improvement (QAPI) committee. A log of notifications and fund conveyances will be maintained and reviewed monthly. The results of these audits will be submitted at QAPI. The Administrator is responsible for execution and monitoring of this POC.	

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F0569 SS = E	Continued from page 2 Resident #80 had an account balance of NJ Exec Order 26.4b as of NJ Exec Ord. The US FOIA 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 NJ Exec Order 26.4 as of NJ Exec Ord. The US FOIA stated that the quarterly statements were mailed to the resident's representative. Resident #173 had an account balance of NJ Exec Order 26.4 as of NJ Exec Orde The US FOIA stated that the resident had an NJ Exec Order 26.4b1 that was returned NJ Exec Order 2 after surveyor inquiry. Resident #186 had an account balance of NJ Exec Order 26.4 as of NJ Exec Orde The US FOIA stated that the quarterly statements were mailed to the resident's representative. On 8/14/25 at 10:23 AM, the surveyor interviewed the US FOIA (b)(6)) 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 8/14/25 at 11:51 AM, during a follow-up interview the US FOIA 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 NJ Exec Order 26.4b1 The US FOIA then stated that they did encourage residents to spend down their monies. 2.) On 8/14/25 at 9:55 AM, the surveyor interviewed the US FOIA 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 08/14/25 at 11:02 AM, the surveyor reviewed the electronic medical records (EMR) census which reflected the following: Resident #239 NJ Exec Order on NJ Exec Order 2	F0569		

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F0569 SS = E	Continued from page 3 Resident #241 NJ Exec Order on NJ Exec Order 26.4 Resident #243 was discharged on NJ Exec Orde Resident #245 was discharged on NJ Exec Order 2 Resident #248 was discharged NJ Exec Order 2 Resident #249 NJ Exec Order on NJ Exec Order 2 On 8/14/25 at 10:12 AM, the US FOIA and the surveyor reviewed the Resident Activity List, and the US FOIA confirmed it was for NJ Exec Order, which was the last quarterly. At that time, the surveyor and US FOIA then reviewed the Resident Activity List and the Resident Statement Landscape as of NJ Exec Order 2 which indicated the following: Resident #239 had an account balance of NJ Exec Order 26.4b1 with NJ Exec Order 26.4b1, was NJ Exec Order 26.4b and the funds were not returned to Medicaid within 30 days. Resident #241 had an account balance of NJ Exec Order 26.4 with NJ Exec Order 26.4b1, was NJ Exec Order 26.4b and the funds were not returned to Medicaid within 30 days. Resident #243 had an account balance of NJ Exec Order 26.4b1 with NJ Exec Order 26.4b1, was discharged but then NJ Exec Order 2 and the funds were not returned within 30 days. The US FOIA 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 NJ Ex Order 26.4(b), 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 NJ Exec Order 26.4b1 with NJ Exec Order 26.4b1 was discharged, and the funds were not returned to the State. Resident #249 had an account balance of NJ Exec Order 26.4b1 with NJ Exec Order 26.4b1, was NJ Exec Order 26.4b and the funds were not returned to Medicaid. At that time, the US FOIA stated she would have to follow up with the U.S. F on why the funds were "just now being	F0569		

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F0569 SS = E	Continued from page 4 returned." She acknowledged the funds should have been returned prior to surveyor inquiry. On 8/14/25 at 10:20 AM, in the presence of the [redacted]) the surveyor interviewed the [redacted] 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 8/18/25 at 9:49 AM, the [redacted] acknowledged in the presence of the [redacted]) 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 August 2020, 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	F0569		
F0686 SS = D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary	F0686	Element #1 The [redacted] for resident #7 was immediately turned on and adjusted to the correct setting of [redacted], based on the resident's most recent [redacted]. The nurse responsible was re-educated on the importance of following physician orders and verifying [redacted] settings. A [redacted] assessment was completed to ensure no [redacted] occurred due to the [redacted] setting. Element #2	09/15/2025

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F0686 SS = D	Continued from page 5 treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to ensure a NJ Exec Order 26.4b1 was operating and set according to the resident's NJ Exec Orde as per a physician's order for a resident previously identified as being at risk for NJ Exec Order 26 [redacted] This deficient practice was identified for 1 of 4 residents (Resident #7) reviewed for NJ Exec Order 26.4b1 and NJ Exec Order 2 and was evidenced by the following: On 8/8/2025 at 10:46 AM, the surveyor observed Resident #7 lying in bed awake. The NJ Exec Order 26 was noted to be NJ Exec Order 2 however, the NJ Exec Order 26.4b1 [redacted] was not on at that time. There was a piece of tape on the machine, with 'NJ Exec Order 26.4b1 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 NJ Exec Order 26.4b1 was set to NJ Exec Order 2 A review of the Admission Record, an admission summary, revealed the resident had diagnoses which included, but were not limited to: NJ Exec Order 26.4b1 [redacted]. A review of the resident's most recent comprehensive Minimum Data Set (MDS), an assessment tool, dated NJ Exec Order 26.4 , included the resident had a Brief Interview for Mental Status (BIMS) score of NJ E out of 15, which indicated the resident's NJ Exec Order 26.4b1 . A review of the resident's individual comprehensive care plan (ICCP) included a focus area, dated NJ Exec Order 26.4 , included that the resident was at risk for NJ Exec Order 26.4b1 [redacted]. The interventions included: NJ Exec Order 26.4b1 to bed and NJ Exec Order 26.4b1 for NJ Exec Order 26.4b1 every shift. A review of the Order Summary Report (OSR), included the following physician orders (PO): A PO, dated NJ Exec Order 26.4 [redacted], for NJ Exec Order 26.4b1 and to check the setting closest to resident's NJ Exec Order 26.4b1 , and check the NJ Exec Order 26.4b1	F0686	Continued from page 5 All residents have the potential to be affected by this deficient practice. A facility-wide audit was conducted to identify all residents with low-air-loss mattresses. No issue found. Element #3 Policy Update: The facility's policy on support surfaces was revised to include: Verification of mattress functionality and settings at the beginning of each shift. Documentation of mattress checks in the Treatment Administration Record (TAR). Staff Education: All nursing staff (RNs, LPNs, CNAs) received in-service training on: Proper use and monitoring of low-air-loss mattresses. Element #4 A weekly audit x6 tool was implemented to ensure: Mattress settings match resident weights. Functionality checks are documented. Unit Managers will review audit results weekly x6 then monthly for 3 months and report findings to the Director of Nursing (DON). The DON will present monthly compliance data to the QAPI Committee for review and follow-up. The results of these audits will be submitted at QAPI. The Director of Nursing is responsible for execution and monitoring of this POC.	

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F0686 SS = D	Continued from page 6 A review of the NJ Exec Order 26.4b1 Medication Administration Record (MAR) and Treatment Administration Record (TAR) revealed that the NJ Exec Order 26.4b1 was signed off by the nurse as administered on NJ Exec Order 26.4b1. A review of the NJ Exec Order in the resident's electronic health record (EHR) indicated that on NJ Exec Order 26.4b the resident NJ Exec Order 26.4b1. On 8/13/2025 at 12:05 PM, the surveyor interviewed Licensed Practical Nurse (LPN) #2, who stated that the settings on the NJ Exec Order 26.4b1 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 NJ Exec O to the resident or worsen a NJ Exec Order 26.4b1. On 8/13/2025 at 12:15 PM, the surveyor interviewed Licensed Practical Nurse/Unit Manager (LPN/UM) #3, who stated that the NJ Exec Order 26.4b1 should be functioning and set according to the resident's NJ Exec Orde She further noted that the setting should not go beyond the resident's NJ Exec Orde and on every shift, the Certified Nurse Aides (CNAs) and LPNs should ensure that it was NJ Exec Order and NJ Exec Order 26.4b1 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 NJ Exec Order 26.4b1 should have been set to NJ Exec . On 8/13/2025 at 1:07 PM, the surveyor interviewed the US FOIA (b)(6)), who stated that the PO specified the NJ Exec Order 26.4b1 should be set to the number closest to the resident's NJ Exec Orde 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 setting A 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)	F0686		
F0755 SS = D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3)	F0755	Element #1: Staff Counseling & Education: LPN #1 was immediately	09/15/2025

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F0755 SS = D	Continued from page 7 §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by: 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 [redacted] 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	F0755	Continued from page 7 counseled and re-educated on the facility's Controlled Substance Management policy. Inventory Reconciliation: A full reconciliation of the [redacted] inventory was completed for all residents on [redacted] including Residents #128, #99, and #152. Documentation & Reporting: Missing documentation was completed. All discrepancies were reported to the Director of Nursing (DON) and investigated accordingly. Element #2: All residents have the potential to be affected by this deficient practice. Corrective Measures Taken: A comprehensive audit of all controlled medication records across all nursing units was conducted. No additional residents were found to be adversely affected. All nursing staff were interviewed to ensure compliance with documentation protocols. Element #3: Policy Reinforcement: The facility's Controlled Substance Management policy was reviewed on September 1, 2025. No changes were deemed necessary. Staff Education: All licensed nurses received mandatory in-service training on: Controlled substance documentation and reconciliation procedures. Joint shift-to-shift narcotic counts by incoming and outgoing nurses. Transfer of the narcotic book to the incoming nurse at shift change. Immediate signing out of medications upon administration.	

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F0755 SS = D	Continued from page 8 review the "Shift Count" [redacted] 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 [redacted] count was done and there were no discrepancies. At that time, the surveyor requested to view and count the full [redacted] 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 [redacted] tablets and the Declining Inventory Sheet (DIS) indicated that there were 21 tablets remaining. Upon inspection of the bingo cards, there were only [redacted] 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 [redacted] 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 [redacted] 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 [redacted]) 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 [redacted]) 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.	F0755	Continued from page 8 Accountability Measures: Supervisors will conduct random audits to verify narcotic counts and documentation accuracy. Element #4: Audit Schedule: The DON or designee will conduct: Weekly audits for 4 weeks. Bi-weekly audits for 2 months. Monthly audits thereafter for 6 months. Review & Follow-Up: Audit results will be reviewed during monthly QAPI (Quality Assurance and Performance Improvement) meetings. Any discrepancies will be addressed immediately, with retraining provided as needed. Audit outcomes will be submitted and discussed at QAPI meetings.	

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F0755 SS = D	Continued from page 9 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 [NJ Exec Order 26.7] medications together and sign the book upon completion to ensure that the [NJ Exec Order] count inventory was correct and there were no medication errors. LPN/UM #1 stated that as soon as the [NJ Exec Order 26.4] 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 [NJ Exec Order 26.4] 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 [US FOIA (b)(6)] who stated that it was important to do the shift-to-shift count to ensure that the narcotic count was accurate. The [US FOIA] stated that the incoming nurse should have notified the [US FOIA] to obtain the book from the 11-7 nurse at shift change. The [US FOIA] stated that the incoming nurse should assume responsibility of the [NJ Exec Order] book because they were responsible for the [NJ Exec Order 2] inventory in the cart during their shift. The [US FOIA] stated that she counted with the 11-7 nurse at 6:50 AM, and the cart was accurate, because LPN #1 was late. The [US FOIA] 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 [NJ Exec Order 2] you are to sign it out immediately. The [US FOIA] 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 [US FOIA (b)(6)] 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	F0755		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315174	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 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, New Jersey, 08096**

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F0755 SS = D	Continued from page 10 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)	F0755		
F0756 SS = D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the	F0756	Element #1 • Resident #185's medication order for [redacted] was immediately reviewed. • The prescribing practitioner clarified the diagnosis and updated the medication order to reflect the appropriate clinical indication (e.g., [redacted] • Documentation of the pharmacist's recommendation and the physician's response was entered into the resident's medical record. Element #2 All residents have the potential to be affected by this deficient practice. A facility-wide audit of Consultant Pharmacist reports from the past 3 months was conducted. All recommendations were reviewed to ensure appropriate follow-up and documentation. All outstanding recommendations were addressed, and physician responses were documented in the respective residents' medical records. Element #3	09/15/2025

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F0756 SS = D	Continued from page 11 resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is NOT MET as evidenced by: 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 US FOIA (b)(6)) 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 NJ Exec Orde for NJ Exec Order 26.4b1) Give one (1) tablet by mouth one time a day for NJ Exec Order 26.4b1 The surveyor reviewed the diagnoses listed on the resident's OSR which failed to include a medical diagnosis of NJ Exec Order 26.4b1 A review of Resident #185's NJ Exec Order 26.4b1 Medication Administration Record (MAR) revealed that the resident was ordered NJ Exec Order 26.4b1 Give 1 tablet by mouth one time a day for NJ Exec Order 26.4b1 The medication was scheduled to be administered between 7 AM - 10 AM and had been administered daily from NJ Exec Order 26.4b1. A review of the US FOIA (b)(6) Inspection Report dated NJ Exec Orde revealed a recommendation to, "Please clarify NJ Exec Order 26.4b1 ordered for NJ Exec Order 26.4b1 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.	F0756	Continued from page 11 Policy Update: The facility's Medication Regimen Review (MRR) policy was reviewed no changes need. The Director of Nursing (DON) or designee will verify completion of physician responses within the required timeframe. Staff Education: Physicians, Nurse Practitioners, and nursing leadership were re-educated on F0756 requirements, including documentation of rationale when no changes are made. Unit Managers were trained to ensure timely delivery and follow-up of pharmacist recommendations. Element #4 The DON will conduct monthly audits x6 of Consultant Pharmacist reports and physician responses. Audit results will be reviewed during QAPI meetings. Any delays or omissions will be addressed immediately, and retraining will be provided as needed. The results of these audits will be submitted at QAPI. The Director of Nursing is responsible for execution and monitoring of this POC.	

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F0756 SS = D	Continued from page 12 A review of a US FOIA (b)(6) Consultation Note dated NJ Exec Orde at 12:30 PM revealed: "Medication Regimen Reviewed. No recommendations made." A review of a US FOIA (b)(6) Consultation Note dated NJ Exec Orde 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 NJ Exec Order 26.4b1 Recommendations were forwarded to her from the US FOIA (b)(6) via email. LPN/UM #2 stated that she then printed the recommendations out and gave them to the US FOIA (b) for review. LPN/UM #2 stated that the US FO 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 US FOIA (b)(6) Inspection Report dated NJ Exec Orde, in which the US FO signed that he/she was in agreement with the US FO recommendations to clarify fludrocortisone ordered for NJ Exec Order 26.4b1 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 NJ Exec Order 26.4b1 was an appropriate diagnosis for the medication. On 8/14/25 at 2:08 PM, the surveyor interviewed the facility supplier pharmacy US FOIA (b)(6) who stated that NJ Exec Order 26.4b1 was originally ordered on NJ Exec Order for an indication of NJ Exec Order 26.4b1). He further stated that when the medication was reordered on NJ Exec Order the indication for NJ Exec Order 26.4b1 was not clarified. On 8/14/25 at 2:30 PM, the surveyor interviewed the US FOIA (b)(6)) who stated that the facility changed US FOIA (b)(6) Providers back in NJ Exec Order 26.4b1. The US FOIA (b)(stated that the CP emailed the recommendation to her or the US FOIA (b)(6) , and the recommendations were printed out and were then given to the physician for review to see if they agree or disagree. The US FOIA (b)(stated that if the physician did agree, then they updated the order, and we make sure that the recommendation was followed through. The US FOIA (b)(stated that the US FO should have provided the correct diagnosis if she signed off in agreement. The US FOIA (b)(stated that the US FOIA (b)(6) sat down and went over the recommendations with the US FO and the recommendation should have been clarified at that	F0756		

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F0756 SS = D	Continued from page 13 time. On 8/18/25 at 9:36 AM, in the presence of the survey team, the US FOIA (b)(6) was made aware of the concerns related to the failure of the facility to act upon the US FOIA (b)(6) recommendations in a timely manner. A review of the facility's "Medication Regimen Reviews (MRR)" policy, revised November 2021), included: The Consultant Pharmacist 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	F0756		
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.	F0812	Element #1 All identified kitchen equipment was immediately deep-cleaned and sanitized. The can opener blade was replaced, and the unit was sanitized. Maintenance and cleaning logs were created and implemented for all food service equipment. Element #2 All residents have the potential to be affected by this deficient practice. Based on resident record review, there was no signs or symptoms of food borne illness therefore there was no identified resident affected by this deficient practice.	09/15/2025

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F0812 SS = F	Continued from page 14 §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: 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 [redacted], the surveyor observed the following: 1. The microwave had multicolored dried stuck on debris on the interior ceiling of the unit. The [redacted] 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 [redacted] 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 [redacted] 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 [redacted] 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 [redacted] 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 [redacted] stated,	F0812	Continued from page 14 Element #3 The facility policy on Food Procurement was reviewed and determined to be compliant with state and federal regulations. A cleaning schedule for all kitchen equipment with daily, weekly, and monthly tasks. A maintenance log for equipment requiring blade or part replacement. A checklist for sanitation verification signed by the FSD or designee. Staff Training: All dietary staff received in-service training on food safety, sanitation protocols, and documentation procedures. Training included proper cleaning techniques and the importance of preventing foodborne illness. Element #4 The FSD will perform daily checks for 6 weeks and document cleaning and maintenance activities. The administrator/ Designee will complete weekly random audits of the kitchen to ensure the kitchen is clean and any audit findings are being addressed the administrator/ Designee will document audits and review in monthly QAPI meeting. The Administrator is responsible for execution and monitoring of this POC.	

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F0812 SS = F	Continued from page 15 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 US FOIA acknowledged that it was not cleaned according to facility policy. On 8/8/25 at 10:45 AM, the surveyor interviewed the US FOIA 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 US FOIA (b)(6)), who acknowledged the surveyors concerns after reviewing the pictures of the kitchen equipment. The US FOIA (b) 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 US FOIA (b)(6) 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)	F0812		

New Jersey State Department of Health

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S0000	Initial Comments The facility was in compliance with all of the standards in the New jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long-Term Care facilities.	S0000		09/28/2025

Office of Primary Care and Health Systems Management

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: 315174	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0000	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted on 09/15/2025 in relation to the 08/18/2025 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.

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

New Jersey State Department of Health

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S0000	Initial Comments An offsite/desk review of the facility's Plan of Correction was conducted on 09/15/2025 in relation to the 08/18/2025 State of New Jersey Re-Licensure survey. The facility was found to be in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long-Term Care Facilities	S0000		

Office of Primary Care and Health Systems Management

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: 315174	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING **01 - GREENBRIAR EAST...** B. WING	**08/18/2025**

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K0000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 8//8/25, 8/12/25 and 8/13/25. Deptford Center for Rehabilitation and Healthcare 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. Deptford Center for Rehabilitation and Healthcare is a two-story building. The original building was built in January 1978 of Type I (222) Fire Resistant construction. The building had an addition to the existing building in 1983 with Type I (222) Fire Resistant construction. The facility is divided into 12 smoke zones. The facility has a 85 KW Natural Gas Emergency Generator. The building has a partial lower level/basement that has laundry, storage and utilities. The 1st and 2nd floor resident areas are set up with a center nurse station with A, B, C and D resident wings surrounding the nurse station. The current census was 224 occupied beds and is licensed for 240.	K0000		09/05/2025
K0222 SS = E	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all	K0222	1. Corrective Action for Affected Door The B-stairwell metal exit door was replaced is now in code-compliant. 2. Identification of Other Areas Potentially Affected All residents have the potential to be affected. A full inspection of all exit doors throughout the facility was conducted by the Maintenance Director. No additional doors were found to impede emergency egress. 3. Systemic Changes to Prevent Recurrence	11/18/2025

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: 315174	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING **01 - GREENBRIAR EAST...** B. WING	**08/18/2025**

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Deptford Center for Rehabilitation and Healthcare	**1511 CLEMENTS BRIDGE RD , DEPTFORD, New Jersey, 08096**

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K0222 SS = E	Continued from page 1 locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This STANDARD is NOT MET as evidenced by: Based on observation and interview on 8/12/25 in the	K0222	Continued from page 1 Policy Update: The facility's Life Safety and Maintenance policies were reviewed no changes necessary. The maintenance director will conduct Monthly inspections of all egress doors for 6 months for proper operation, corrosion, and compliance with NFPA 101. These audits will be reviewed by the administrator monthly. Immediate reporting and documentation of any door that does not meet egress standards. Staff Training: The administrator provided Maintenance staff education training on NFPA 101 requirements for egress doors, including acceptable force thresholds and single-action release mechanisms. The administrator also trained the maintenance staff to recognize signs of rust and mechanical failure and to report issues promptly. 4. Monitoring and Quality Assurance The Maintenance Director will conduct monthly audits for 6 months of all egress doors and document findings on new audit sheet that was created on 9/3/25. Audit results will be reviewed during quarterly QAPI meeting, Any deficiencies will be corrected immediately and tracked through the facility's work order system.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315174	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - GREENBRIAR EAST... B. WING	(X3) DATE SURVEY COMPLETED 08/18/2025

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K0222 SS = E	Continued from page 2 presence of the US FOIA (b)(6) [redacted], it was determined that the facility failed to provide exit doors in the means of egress readily accessible and free of all obstructions or impediments to full instant use in the case of fire or other emergencies in accordance with the requirements of NFPA 101, 2012 Edition, Section 7.2.1.6.1.1(3)a, 19.2.2.2.5.1, 19.2.2.2.5.2 and 19.2.2.2.6. The deficient practice had the potential to affect 60 of 224 residents and was evidenced by the following: Observations at 12:11 PM, on 8/12/25 with the US FOIA (b)(6) [redacted], revealed that the metal exit/egress door in the B-stairwell did not open freely. The US FO [redacted] used his full body weight to force open the door because the door was caught against the door frame. The releasing of the delayed egress mechanism by pushing the panic bar device and door was not a single action and it took greater than fifteen pounds of force to open the door that could impede or prevent emergency use. The metal door was observed to have a heavy rust condition on the bottom edge and when the door was opened, rusted metal was observed outside the door area. I an interview with the US FOIA (b)(6) during the observation, both indicated that the door was stuck into the metal frame and had a heavy rust condition. The US FOIA (b)(6) both indicated the door needed to be replaced. The facility's US FOIA (b)(6) was informed of the deficient practice at the Life Safety Code exit conference on 8/13/25 at 1:00 PM. NJAC 8:39-31.2(e)	K0222		
K0511 SS = D	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This STANDARD is NOT MET as evidenced by:	K0511	1. Corrective Action for Affected Area The hydrocollator was unplugged and relocated to a GFCI outlet located on the other side of the GYM. 2. Identification of Other Areas Potentially Affected All residents have the potential to be affected. A facility-wide audit of all electrical outlets in resident care and therapy areas was conducted.	11/18/2025

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K0511 SS = D	Continued from page 3 Based on observation and interview on 8/12/25 in the presence of the US FOIA (b)(6) [redacted] it was determined that the facility failed to ensure that electrical equipment had approved wiring and electrical outlets in accordance with NFPA 99: -6.3.2.1, NFPA 70: 2011 Edition, Section 19.5.1.1, 9.1.1 and 9.1.2. The deficient practice was identified for 1 of 6 electrical outlets observed, had the potential to affect residents in the area of the Physical Therapy room and was evidenced by the following: An observation at 11:10 AM with the US FOIA (b)(6) in the Physical Therapy Room, revealed that the portable hydrocollator (a device used in physical therapy) was full of water and plugged into a non- GFCI (ground-fault circuit interrupter) duplex wall outlet. In an interview at the time, the US FOIA (b)(6) both acknowledged that the current electrical duplex wall outlet could not be identified as a ground-fault circuit interrupter (GFCI). The US FOIA (b)(6) was informed of the deficient practice at the Life Safety Code exit conference on 8/13/25 at 1:00 PM. NJAC 8:39 -31.2 (e) NFPA 70, 99	K0511	Continued from page 3 On 9/2/2025 all outlets near water sources or in wet locations were inspected for GFCI compliance. No other issues were found. 3. Systemic Changes to Prevent Recurrence The Maintenance director will perform annual inspections of all outlets in wet or patient care areas. These audits will be given to the administrator for review. Immediate reporting and remediation of any non-GFCI outlets found in high-risk zones. Staff Training: The administrator provided education to the maintenance staff on NFPA 70 and NFPA 99 standards. Therapy and nursing staff were educated by the facility maintenance director on the importance of using GFCI outlets for equipment near water sources. 4. Monitoring and Quality Assurance The Maintenance Director will conduct quarterly audits of electrical outlets in all therapy, clinical, and wet areas. Audit results will be reviewed during monthly QAPI meetings and tracked for compliance.	
K0761 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	K0761	1. Corrective Action for Identified Deficiency The facility immediately conducted and documented a full inspection and functional testing of all fire-rated door assemblies. No new issues were found. 2. Identification of Other Areas Potentially Affected All residents have the potential to be affected. A facility-wide review was conducted to identify all	09/24/2025

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K0761 SS = F	Continued from page 4 possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This STANDARD is NOT MET as evidenced by: Based on a record review and interview from 8/8/25 to 08/13/2025 in the presence of the US FOIA (b)(6) [redacted]), it was determined that the facility failed to ensure that fire door assemblies were inspected, tested and maintained (ITM) annually in accordance with NFPA 101:2012 Edition, Sections 7.2.1.15 and the minimum requirements of NFPA 80:2010 Edition, Section 5.2.1 and 5.2.4.2 (1) - (11). This deficient practice had the potential to affect all residents and was evidenced by the following: A record review on 8/8/25 revealed that annual fire door assemblies' inspections and functional testing performed by individuals who can demonstrate knowledge and understanding of the operating components and the minimum requirements of NFPA 80 were not conducted. In an interview at the time, the US FOIA [redacted] confirmed that he did not inspect the fire doors in the facility at this time. The facility's US FOIA (b)(6) was informed of the deficient practice that the Life Safety Code exit conference on 8/8/25 at 1:00 PM. N.J.A.C 8:39-31.2 (e) NFPA 80	K0761	Continued from page 4 fire-rated doors, smoke barrier doors, and corridor doors. No additional deficiencies were found. 3. Systemic Changes to Prevent Recurrence Policy Update: The facility's Life Safety and Maintenance policies were revised to include: Annual fire door inspections and functional testing by the corporate maintenance director. Documentation of inspection results. Staff Training: The US FOIA (b)(6) [redacted] and designated staff received education from the administrator on NFPA 80 requirements and inspection procedures. Monitoring and Quality Assurance The Director of Maintenance will maintain a Fire Door Inspection Log with dates, findings, and corrective actions. Annual inspections will be scheduled and tracked using the facility's compliance calendar. Inspection records will be reviewed during quarterly QAPI Committee meetings.	
K0918 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	K0918	1. Corrective Action for Identified Deficiency The facility immediately scheduled and completed a 90-minute load bank test of the emergency generator to confirm its ability to meet the required load. The generator's monthly load test was conducted at no less than 30% of the unit's nameplate rating, as verified by the generator's onboard load gauge and documented on	11/19/2025

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K0918 SS = F	Continued from page 5 within 10 seconds. If the 10-second criterion is not met during the monthly test, a 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 STANDARD is NOT MET as evidenced by: Based on record reviews and interview on 8/12/25 in the presence of the US FOIA (b)(6)), it was determined the facility failed to ensure the Emergency Power Supply (EPS) was exercised at 30% or greater of its nameplate rating during the monthly load tests or perform a 90 minute annual load bank test and failed to properly document the monthly testing of the emergency generator in accordance with NFPA 101: 2012 edition, NFPA 99: 2012 edition, Sections 6.4.4, 6.5.4, 6.6.4, and NFPA 110: 2010 edition, Sections: 8.1.1, 8.4, 8.4.1, 8.4.2, 8.4.2.3, 8.4.9, and 8.4.9.1 to 8.4.9.7. This deficient practice had the potential to affect all residents and was evidenced by the following: A record review of the generator monthly load test log revealed that the generator was not exercised at least 30% of the name plate rating or perform a 90-minute annual load bank test was not conducted. In an interview at the time of record review, the US FO confirmed the above findings.	K0918	Continued from page 5 the monthly testing log. All testing was performed by qualified personnel and documented in accordance with NFPA 110 standards. 2. Identification of Other Areas Potentially Affected All residents have the potential to be affected. No additional deficiencies were found, but preventive maintenance was performed to ensure system readiness. 3. Systemic Changes to Prevent Recurrence Documentation of cold starts, transfer switch operation, and load conditions. Staff Training: Maintenance department was educated on running the monthly load test at 30% of the nameplate rating and documenting, by checking the gauge on the generator. 4. Monitoring and Quality Assurance The Maintenance Director will maintain a Generator Testing Log that includes: Date and time of test Load percentage Duration Transfer switch operation Cold start verification Logs will be reviewed monthly by the Administrator and quarterly by the QAPI Committee.	

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K0918 SS = F	Continued from page 6 The US FOIA (b)(6) was informed of the deficient practice at the Life Safety Code exit conference on 8/13/25 at 1:00 PM. N.J.A.C. 8:39-31.2 (e) NFPA 99,110	K0918		
K0920 SS = E	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 8/12/25 in the presence of the US FOIA (b)(6) [redacted] it was determined that the facility failed to prohibit the use of extension cords and power 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 was identified for 8 of 8 electrical observations, had the potential to affect all residents in the facility and was evidenced by the following:	K0920	1. Corrective Action for Identified Deficiencies All extension cords used for portable air conditioning units in resident rooms NJ Exec Order 26.4b1 [redacted] were immediately removed. All affected areas were reinspected to ensure compliance. 2. Identification of Other Areas Potentially Affected All residents have the potential to be affected. A facility-wide audit was conducted to identify all uses of extension cords and power strips. No additional violations were found. 3. Systemic Changes to Prevent Recurrence Policy Update: The facility's electrical safety policy was reviewed no changes needed. Prohibition of extension cords for permanent use. Approved use of power strips only for low-draw, non-patient-care equipment in resident rooms. All power strips must meet UL 1363 or UL 1363A standards depending on location and use. Staff Training: The administrator provided education to the Maintenance staff and administrative staff on NFPA 70 and NFPA 99 requirements.	09/24/2025

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K0920 SS = E	Continued from page 7 1). Observations from 9:15 AM to 12:30 PM revealed that in the following resident rooms, portable A/C units were provided along with Packaged Terminal Air Conditioners (PTAC): The PTAC and portable AC units were both in operation. The portable AC units were plugged into energized extension cords in the following resident rooms: NJ Exec Order 26.4b1 In an interview at the time, the US FOIA (b)(6) both verified the findings stated that the extension cords for 5 of 5 portable air conditioner units with extension cords are not to be used as a substitute for fixed wiring of a structure. 2). Observations from 9:15 AM to 12:30 PM also revealed that in the following areas of the facility, multi-outlet power strips were providing power to high-draw appliances: microwaves and refrigerators: Floor #1 ADON office: microwave and refrigerator. Floor #1 Unit Manager office: refrigerator. Floor #2 Unit Manager office: microwave. In an interview at the time, the US FOIA (b)(6) both verified the findings and stated that multi-outlet power strips are not to be used as a substitute for fixed wiring of a structure. The US FOIA (b)(6) was informed of the deficient practice at the Life Safety Code exit conference on 8/13/25 at 1:00 PM. NJAC 8:39-31.2(e) NFPA 70, 99	K0920	Continued from page 7 4. Monitoring and Quality Assurance The Maintenance Director will conduct monthly audits for 6 months of all resident rooms, therapy areas, and offices to ensure compliance. A log of inspections and corrective actions will be maintained and reviewed during quarterly QAPI Committee meetings.	
K0921 SS = F Bldg. 01	Electrical Equipment - Testing and Maintenanc CFR(s): NFPA 101 Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current,	K0921	1. Corrective Action for Identified Deficiency All electric beds and other PCREE currently in use were immediately inspected and tested for: Physical integrity	09/24/2025

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K0921 SS = F Bldg. 01	Continued from page 8 and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This STANDARD is NOT MET as evidenced by: Based on record review, interview and observation on 8/8/25, 8/12/25 and 8/13/25 in the presence of the US FOIA (b)(6) it was determined that the facility failed to ensure that patient care related electrical equipment (PCREE) was inspected, tested and maintained (ITM) in accordance with NFPA 99:2012 Edition, Chapter 10. This deficient practice had the potential to affect all residents and was evidenced by the following: A record review on 8/8/25 revealed that records of ITM performed in accordance with NFPA 99, Chapter 10, covering but not limited to physical integrity, resistance testing, leakage/touch current and evaluations following any repairs or modifications of PCREE could not be produced. In an interview at the time, the US FO confirmed the record review and indicated that patient electric beds were not annually inspected. An observation from 09:30 AM, to 12:30, PM with the US FO and US FOI revealed that no inspection stickers were identified on resident electric beds.	K0921	Continued from page 8 Grounding resistance Leakage and touch current Inspection stickers were affixed to each bed and device, indicating the date of testing and technician initials. A log of all inspections and test results was created and filed in the Life Safety compliance binder. 2. Identification of Other Areas Potentially Affected All residents have the potential to be affected. A facility-wide inventory of all PCREE was conducted, including: Beds, lifts, therapy equipment, and diagnostic devices. Any equipment lacking inspection documentation was tested and labeled. No additional deficiencies were found, but preventive testing was completed for all units. 3. Systemic Changes to Prevent Recurrence Policy Update: The facility's electrical equipment maintenance policy was revised to include: Initial testing of all PCREE before being placed into service. Annual testing of all PCREE for integrity, resistance, and leakage current. Documentation Protocol: A centralized log will be maintained for all PCREE inspections, repairs, and modifications.	

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K0921 SS = F Bldg. 01	Continued from page 9 The facility's US FOIA (b)(6) was informed of the deficient practice at the Life Safety Code exit conference on 8/13/25 at 1:00 PM. N.J.A.C 8:39-31.2(e) NFPA 99	K0921	Continued from page 9 Staff Training: The administrator provided education to the Maintenance and engineering on NFPA 99 Chapter 10 requirements. 4. Monitoring and Quality Assurance The Maintenance Director will conduct quarterly audits for 1 year of PCREE logs and physical inspection stickers. Audit results will be reviewed during monthly QAPI and Committee meetings.	

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E0000	Initial Comments This facility was not in substantial compliance with Medicare/Medicaid at 42 CFR, Subpart 483.73, Emergency Preparedness Requirements for Long Term Care (LTC) Facilities.	E0000		09/28/2025
E0004 SS = F	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually.	E0004	1. Corrective Action for Identified Deficiencies All outdated emergency preparedness policies and agreements were immediately reviewed and updated, including: Flood response policy Emergency generator maintenance Utility interruption procedures Evacuation protocols for bariatric residents Emergency food and water supply agreement Disaster preparedness plans with medical and pharmacy vendors Transfer agreements with receiving facilities Emergency contact lists for department heads and unit managers Updated documents were signed, dated, and filed in the Emergency Preparedness binder. 2. Identification of Other Areas Potentially Affected All residents have the potential to be affected by this deficient practice. A full audit of the Emergency Preparedness Program was conducted to identify any additional outdated or	11/18/2025

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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: 315174	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 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, New Jersey, 08096**

(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
E0004 SS = F	Continued from page 1 * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This STANDARD is NOT MET as evidenced by: Based on interview and review of facility documents on 8/13/25, it was determined the facility failed to establish and maintain the facility transfer contracts and agreements at least annually in accordance with Appendix Z, §483.73(a): Emergency Plan. This deficient practice had the potential to affect all residents and was evidenced by the following: A review of the facility documents at 10:05 AM, revealed that facility contracts, contacts, and transfer agreements were not updated at least annually. The following contracts and transfer agreements not annually updated: 1. Policy for flood last updated: 2/2022. 2. Policy for maintaining the emergency generator power system last updated: 2/2022. 3. Policy for interruption of utility services (HVAC) last reviewed: 5/2023. 4. Policy for EP plan for evacuation for NJ Exec Order 2 resident: 8/2023 5. Emergency service & rental generators last revised: 7/2023. 6. In-house dietary department will supply Deptford Center with water and food last revised: 2/2023. 7. {Vendor Name} disaster preparedness and response plan for continued availability of essential medical and surgical supplies updated: 5/2018. 8. Pharmacy agreement: 3/2018. 9. Transfer agreement NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 dated: 1/2023. 10. Department heads unit manager emergency contact numbers has a different facility administrator name.	E0004	Continued from page 1 missing documentation. All emergency-related contracts, MOUs, and vendor agreements were reviewed for compliance with CMS and local emergency management requirements. No additional deficiencies were found, but preventive updates were completed. 3. Systemic Changes to Prevent Recurrence Policy Update: The Emergency Preparedness policy was reviewed no changes needed. Staff Training: The Administrator, Emergency Preparedness Coordinator, and department heads received training from the Facility Educator on CMS Appendix Z requirements. The administrator educated the U.S. FOIA (b) (6) on the importance of maintaining current emergency plans and vendor agreements. 4. Monitoring and Quality Assurance A quarterly audit of the Emergency Preparedness Program will be conducted by the facility administrator and reviewed during the monthly QAPI meetings. Any expired or missing documents will be flagged and updated within 10 business days.	

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E0004 SS = F	Continued from page 2 In an interview at the time of document review, the US FOIA (b)(6) both indicated the above documents were not updated as of this survey. The US FOIA (b)(6) was informed of the deficient practice at the Life Safety Code exit conference on 8/13/25 at 1:00 PM. NJAC 8:39-31.2(e), 31.6(i)	E0004		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315174	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING **01 - GREENBRIAR EAST...** B. WING	**11/19/2025**

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Deptford Center for Rehabilitation and Healthcare	**1511 CLEMENTS BRIDGE RD , DEPTFORD, New Jersey, 08096**

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K0000	INITIAL COMMENTS An on-site revisit was conducted on 11/19/2025 to verify the facility's Plan of Correction for the 8/18/2025 Recertification survey. The facility was found to be in non-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. Deptford Center for Rehabilitation and Healthcare is a two-story building. The original building was built in January 1978 of Type I (222) Fire Resistant construction. The building had an addition to the existing building in 1983 with Type I (222) Fire Resistant construction. The facility is divided into 12 smoke zones. The facility has a 85 KW Natural Gas Emergency Generator. The building has a partial lower level/basement that has laundry, storage and utilities. The 1st and 2nd floor resident areas are set up with a center nurse station with A, B, C and D resident wings surrounding the nurse station. The current census was 223 occupied beds and is licensed for 240.	K0000		11/28/2025
K0921 SS = F Bldg. 01	Electrical Equipment - Testing and Maintenanc CFR(s): NFPA 101 Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by	K0921	1. Corrective Action for Identified Deficiency All electric beds located on units 1C, 1D, 2A, 2B, 2C, and 2D were retested on 11/19/2025, and testing was completed by 12:30 PM. Testing included: Physical integrity Grounding resistance Leakage and touch current Inspection stickers were affixed to each bed showing	09/24/2025

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315174	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 01 - GREENBRIAR EAST... B. WING	11/19/2025

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K0921 SS = F Bldg. 01	Continued from page 1 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This STANDARD is NOT MET as evidenced by: REPEAT DEFICIENCY from the Recertification survey of 08/18/2025. Based on Observations, Review of Documentation and Interview on 11/19/2025 in the presence of the facility's US FOIA (b)(6)), it was determined that the facility failed to ensure that all patient care related electrical equipment (PCREE) was inspected, tested, maintained and tagged with the date and initials of the person who inspected the equipment in accordance with NFPA 99, 2012 Edition, Chapter 10. This deficient practice had the potential to affect the Residents on the first floor "C and D" units and the Residents on the second floor "A, B, C and D" units and was evidence by the following: During the survey entrance on 11/19/2025 at approximately 9:14 AM, a request was made to the US FOIA (b)(6) to provide a copy of the PDREE inspections that had been conducted as part of the facility's Plan of Correction (POC) with a completion date of 09/24/2025. The facility's POC reads in part: "1. Corrective action for the identified Deficiency, - All electric beds and other PCREE currently in use were immediately inspected and tested for: Physical integrity, Grounding resistance, Leakage and touch current. - Inspection stickers were affixed to each bed and device, indication the date of testing and technician initials. - A log of all inspections and test results was created and filed in the Life Safety compliance binder. Observations during the tour of the second floor, starting at approximately 9:25 AM in the presence of	K0921	Continued from page 1 the date of testing and initials of the technician. A new log of inspections and test results was created and filed in the Life Safety Compliance Binder. 2. Identification of Other Areas Potentially Affected All residents have the potential to be affected. A facility-wide inventory of all PCREE was conducted, including but not limited to: Beds Lifts Therapy equipment Diagnostic devices No additional equipment was found missing inspection stickers. 3. Systemic Changes to Prevent Recurrence Documentation Protocol: A centralized log will be maintained for all PCREE to ensure required testing is completed and inspection stickers are applied per policy. Staff Training: The Administrator provided education to the Maintenance and Engineering departments on NFPA 99 requirements, emphasizing that items required in the POC must be completed and documented by the compliance date. 4. Monitoring and Quality Assurance The Maintenance Director will conduct quarterly audits for one (1) year of PCREE logs and physical inspection stickers. Audit results will be reviewed during monthly QAPI Committee meetings for ongoing compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315174	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING **01 - GREENBRIAR EAST...** B. WING	**11/19/2025**

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K0921 SS = F Bldg. 01	Continued from page 2 the US FOI the surveyor, revealed all Resident beds had no evidence of an electrical inspection sticker conducted (dated with initial of technician) and affixed to the beds. In an interview at this time, the surveyor asked the US FOI "Did you inspect the Residents beds". The US FOI told the surveyor that the beds were inspected and that the first floor A and B unit beds had the stickers affixed to the beds and they were going to go back and put the inspection stickers on the beds later. The US FOI confirmed the findings at the time of observations. The facility's US FOIA (b)(6) were informed of the repeat deficient practice during the Life Safety Code survey exit at approximately12:20 PM. NJAC 8:39-31.2 (e) NFPA 99	K0921		

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E0000	Initial Comments An on-site revisit was conducted on 11/19/2025 to verify the facility's Plan of Correction for the 8/18/2025 Recertification 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		11/28/2025

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		A. BUILDING **01 - GREENBRIAR EAST...** B. WING	**12/06/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K0000 Bldg. 01	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted on 12/6/2025 in relation to the 11/19/2025 onsite revisit for the 8/18/2025 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		12/06/2025

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