

New Jersey Department of Health

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| <b>STATEMENT OF DEFICIENCIES<br/>AND PLAN OF CORRECTIONS</b>                                     |                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>031601</b> |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br><br>B. WING                                          |                                                                                                                          | (X3) DATE SURVEY COMPLETED<br><br><b>02/10/2026</b> |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>ATLAS REHABILITATION HEALTHCARE AT DAUGHTERS OF MOSES</b> |                                                                                                                              |                                                                            |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br><b>155 HAZEL STREET , CLIFTON, New Jersey, 07011</b> |                                                                                                                          |                                                     |                            |
| (X4) ID<br>PREFIX<br>TAG                                                                         | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION) |                                                                            |  | ID<br>PREFIX<br>TAG                                                                               | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE<br>APPROPRIATE DEFICIENCY) |                                                     | (X5)<br>COMPLETION<br>DATE |
| S0000                                                                                            | Initial Comments<br><br>Monitoring visit.                                                                                    |                                                                            |  | S0000                                                                                             |                                                                                                                          |                                                     |                            |

Office of Primary Care and Health Systems Management

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