STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315021	A. BUILDING _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLAS HEALTHCARE AT DAUGHTERS OF MIRIAM	155 HAZEL STREET CLIFTON, NJ 07011

(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
F 000	INITIAL COMMENTS Complaint #: NJ00159240, NJ00159888, NJ00160887, NJ00160934, NJ00162240, NJ00162580, NJ00164077, NJ00164253, NJ00164430, NJ00165101, NJ00165431, NJ00165833, NJ00166123, and NJ00167466 Survey Dates: 10/18/23 - 10/20/23 Survey Census: 192 Sample Size: 12 A Complaint Survey was conducted on behalf of the New Jersey Department of Health. THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and	F 609		12/1/23

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

Electronically Signed | 11/08/2023

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F 609	Continued From page 1 adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Complaint # 165432 Based on interview, record review, and facility policy review, the facility failed to report an injury of unknown origin to the state survey agency for one (Resident (R) 9) of 12 sampled residents reviewed for abuse. Findings Include: Review of R9's "Face Sheet," located under the "Face Sheet" tab of the electronic medical record (EMR), revealed R9 was admitted to the facility on [redacted]2 with diagnoses that included [redacted]. Review of R9's "Care Plan," located under the "Care Plan tab of the EMR and dated [redacted], revealed, "R9 is using a [redacted] medication [redacted] to manage target symptoms [redacted] and being [redacted]." It was recorded R9 had behavioral issues of [redacted] and	F 609	how the corrective action for those residents found to be affected by the deficient practice? Resident number 9 was found to be affected as the facility failed to report an injury of unknown origin. The report was imediatly refaxed to the ombudsman and faxed to the New Jersey department of health. How the facility will identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected. What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not occur. Administrator, DON, ADON and Unit managers educated by the Regional Director on the requirements of F609:Reporting violations. Specifically, education focused on the facility's responsibility to ensure that in response to	

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F 609	Continued From page 2 NJ EX Order. 264b1 on tables. Review of R9's quarterly "Minimum Data Sheet (MDS)," with an assessment reference date (ARD) of NJ EX Order. 264b1 and located under the "MDS" tab of the EMR, revealed R9 had NJ EX Order. 264b1 and was NJ EX Order. 264b1 making. Review of R9's "Progress Notes," dated NJ EX Order. 264b1 at 11:30 as a late entry by Licensed Practical Nurse (LPN) 1 and located under the "Progress Notes" tab of the EMR, revealed, ". . . Responded to the call of CNA [Certified Nurse Aide] for [R9], in the common bathroom referring to NJ EX Order. 264b1 on NJ EX Order. 264b1 which measures NJ EX Order. 264b1] and NJ EX Order. 264b1 I did the assessment and reveals [sic] . . . Mobility on standing/sitting no abnormalities noted, Range of motion, both extremities with equal strength. Residents [sic] denies NJ EX Order. 264b1 during the assessment during touch and motion, no restlessness. Resident stays in the dining room most of the time during the shift, calm. ALL concern [sic] are aware, The supervisor, Manager, [family member] and primary doctor . . ." Review of R9's "Progress Notes," dated NJ EX Order. 264b1 at 12:36 and located under the "Progress Notes" tab of the EMR, revealed R9 had a NJ EX Order. 264b1 to determine any injuries. Review of R9's NJ EX Order. 264b1 Results Report," dated NJ EX Order. 264b1, revealed, ". . . NJ EX Order. 264b1, View of the NJ EX Order. 264b1 show no NJ EX Order. 264b1 . . . NJ EX Order. 264b1 or NJ EX Order. 264b1 is seen . . ."	F 609	injury of unknown origin that it is appropriately and timely reported to the State agency. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur? The Director of Nursing or designee will monitor and review all incident reports and grievances to ensure that facility responds appropriately and investigates and reports all injuries of unknown origin. This will be monitored weekly x 4 weeks then twice monthly for 2 months to enusre ongoing compliance with the deficient practice. The audits will be presented to the Administrator. The DON and or Designee will present the results to the Quality Assurance Performance Improvement Committee for Review on a monthly basis for three months. The Committee will review and revise the plan as needed.	

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F 609	Continued From page 3	F 609		

Review of the facility investigation titled, "#4290 DMC-[redacted] date: [redacted] 11:30", revealed, "0n 624123 [R9] was noted to have [redacted] to [redacted] in [redacted]. investigation started right away. Assessment was done on the entire body and no other NJ EX Order. 264b1 present. MD and family aware. Medical Data: [R9] is an [redacted]-year-old female admitted to the facility on [redacted] with diagnosis that include NJ EX Order. 264b1 [redacted]. She requires NJ EX Order. 264b1 for ADLs and is [redacted] with assistance which [redacted] friend often does. [R9] is [redacted] NJ EX Order. 264b1 and [redacted] and is provided incontinent care as needed. Staff anticipate [redacted] and monitor frequently for [redacted]. [R9] is care planned as behavioral issues as evidenced by physical behaviors including NJ EX Order. 264b1 [redacted] and on tables and [redacted] and NJ EX Order. 264b1 is at high [redacted] for [redacted] and [redacted] related to [redacted] NJ EX Order. 264b1. [R9] was observed [redacted] the [redacted] when [redacted] was seen attempting to stand independently, in the dining room the day before from staff. [redacted] is known for NJ EX Order. 264b1. Conclusion and Interventions: After a complete investigation, review of the medical chart, statements, [redacted] assessment, and pattern of patient [redacted], it is concluded that the resident was seen attempting to stand on [redacted] own and [redacted] into the table. The IDCT [Interdisciplinary Care Team] agrees that there was no evidence of abuse or neglect. The team reviewed the care plan, and it was determined that she will continue to be monitored."

During an interview on 10/20/23 at 1:46 PM, the

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F 609	Continued From page 4	F 609		

Director of Nursing (DON), Assistant Administrator, and Regional Clinical Support stated R9 was NJ EX Order. 264b1 with the staff, had NJ EX Order. 264b1, and liked to NJ EX Order. 264b1 the bedside table, and because she likes to NJ EX Order. 264b1 NJ EX Order. 264b1, a NJ EX Order. 264b1 is kept on the table to prevent injury. The Regional Clinical Support stated the facility's investigation concluded the NJ EX Order. 264b1 noted on NJ EX Order. 264b1 was not abuse and neglect. The Regional Clinical Support confirmed that although the facility did do an investigation of the injury of unknown origin, they did not report it as required to the state survey agency.

Review of the facility's policy titled, "Abuse Neglect and Exploitation," revised February 2023, revealed, "It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property. Alleged Violation is a situation or occurrence that is observed or reported by staff, resident, relative, visitor or others but has not yet been investigated and, if verified, could be indication of noncompliance with the Federal requirements related to mistreatment, exploitation, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property. The facility will designate an Abuse Prevention Coordinator in the facility who is responsible for reporting allegations or suspected abuse, neglect, or exploitation to the state survey agency and other officials in accordance with state law. The facility will have written procedures that include Reporting of all alleged violations to the Administrator, state agency, adult protective

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F 609	Continued From page 5 services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes: a. Immediately, but not later than 2 hours after the allegation is made if the events that cause the allegation involve abuse or result in serious bodily injury, or b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury." NJAC 8:39-9.4 (f)	F 609		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Complaint # NJ 164077 Based on resident and staff interview and medical record review, the facility staff failed to administer physician ordered medications as scheduled for one (Resident (R) 6) of 12 sampled residents. Findings included: Review of R6's "Face Sheet," located in the electronic medical record (EMR), revealed R6 was admitted to the facility on NJ EX Order. 264b1 with diagnoses that included NJ EX Order. 264b1 .	F 684	How the corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident number 6 was found to have been affected by the failure to administer physician ordered medications as scheduled. Resident number 6 was assessed as found to have no negative outcomes from the deficient practice. Nurses were educated on the importance of timely administration of physician	12/1/23

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F 684	Continued From page 6 Review of R6's annual "Minimum Data Set (MDS)," located in EMR, revealed R6 had a "Brief Interview for Mental Status (BIMS)" score of [redacted] which indicated the resident was [redacted]. Review of R6's "Physician's Orders" and "Medication Administration Records (MARS)," located in the EMR, revealed R6 was to receive the following medications: [redacted] an [redacted] medication - [redacted] milligram (mg) orally twice daily; [redacted] a [redacted] - [redacted] mg orally [redacted] daily; [redacted], an [redacted] mg orally [redacted] daily; [redacted] used to treat [redacted] mg orally [redacted] times daily; and [redacted] used to treat [redacted] - [redacted] mg orally [redacted] daily. Review of R6's "Medication Administration Record" (MAR), located in the EMR, revealed the following: [redacted] was scheduled to be given at 7:30 AM; [redacted] was scheduled to be given at 9:00 AM; [redacted] was scheduled to be given at 9:00 AM; [redacted] was scheduled to be given at 2:00 PM; and [redacted] was scheduled to be given at 9:00 AM. Review of R6's "Time Stamp Report" for the month of [redacted], revealed the following: [redacted] was administered at 10:59 AM; [redacted] was administered at 11:02 AM;	F 684	ordered medications. How the facility will identify other residents having the potential to be affected by the same deficient pracitce? All residents have the potential to be affected. What measures will be put into place or systemic changes made to ensure that the deficient pracitce will not recur? All nurses were educated on the importance of timely administration of physician ordered medications. All medications reviewed and audited to ensure proper administration per physician ordered will be maintained. How the facility will monitor its corrective actions to ensure that the deficient practice will not recur. The Director of Nursing or designee will monitor the administered physician ordered medications x 4 weeks then twice monthly for two months to monitor. The audits will be presented to the administrator. The DON or designee will present the results of the audits to the Quality Assurance Performance Improvement Committee for review on a monthly basis for three months. The Committee will review and revise the plan if needed.	

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F 684	Continued From page 7 NJ EX Order. 264b1 was administered at 10:59 AM; and NJ EX Order. 264b1 was administered at 3:15 PM. Review of R6's "Time Stamp Report" for the month of NJ EX Order. 264b1 revealed the following: NJ EX Order. 264b1 was administered at 12:47 PM; NJ EX Order. 264b1 was administered at 9:28 AM; and NJ EX Order. 264b1 was administered at 9:55 AM. During an interview on 10/19/23 at 1:30 PM, R6 stated, "I will get my medications up to two hours late. It doesn't happen all the time, but it does happen." During an interview on 10/20/23 at 2:30 PM, the Director of Nursing (DON) confirmed R6's medications had been administered late on NJ EX Order. 264b1, and NJ EX Order. 264b1. The DON stated, "Medications are to be administrated an hour before or an hour after the time the medication is scheduled. Any medication given outside of those parameters are considered late." NJAC 8:39-27.1 (a)	F 684		

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	031601	A. BUILDING: _____ B. WING _____	C 10/20/2023

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S 000	Initial Comments Complaint #: NJ00159240, NJ00159888, NJ00160887, NJ00160934, NJ00162240, NJ00162580, NJ00164077, NJ00164253, NJ00164430, NJ00165101, NJ00165431, NJ00165833, NJ00166123, and NJ00167466 Survey Dates: 10/18/23 - 10/20/23 Survey Census: 192 Sample Size: 12 The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Complaint # NJ 159240, NJ 162580, NJ 164253 Based on review of pertinent facility documentation, it was determined that the facility failed to ensure staffing ratios were met to maintain the required minimum staff-to-resident ratios as mandated by the state of New Jersey for	S 560	How the corrective action will be accomplished for those residents found to have been affected by the deficient practice? The leadership team has met on an ongoing basis and continues to identify staffing challenges and areas of	12/8/23

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

Electronically Signed | 11/08/23

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S 560	Continued From page 1 34 of 49 day shifts and 1 of 49 overnight shifts as follows: This deficient practice had the potential to affect all residents. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified as N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio (s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer of all staff members shall be CNAs and each direct staff member shall be signed into work as a certified nurse aide and shall perform nurse aide duties: and one direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. As per the "Nurse Staffing Report" completed by the facility for the 7 weeks of staffing from 06/18/2023 to 06/24/2023, 07/02/2023 to 07/08/2023, 07/16/2023 to 07/22/2023, 07/30/2023 to 08/05/2023, 09/10/2023 to 09/16/2023, and 10/01/2023 to 10/14/2023, the staffing to resident ratios did not meet the minimum requirement of one CNA to eight residents for the day shift and one direct care staff member to every 14 residents for the night shift as documented below:	S 560	improvement for certified nursing assistant staffing needs. How the facility will identify other residetns having the potential to be affected by the same dificient practice? Any resident have the potential to be affected. What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not reoccur? The center has implemented significant above market rate for nurses and certified nursing assistants. Incentives include tuition reimbursement, sign-on bonus program, employee referral program, and additional training if not certified. The center continues to conduct ongoing job fairs with immediate interviews, as well as walk-in applicants and has the ability to expedite contingency offers at the time of interview. The center continues to supplement with agency until staff is hired and has secured multiple contracts to assist with filling open shifts. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what QA program will be put into place to monitor the continued effectiveness of the systemic change. The Director of Nursing or designee will monitor the certified nursing aide. Staffing ratios daily and document a weekly review of the daily staffing x4 weeks then twice monthly for two months to monitor. The audits will be presented to the Administrator. The DON/Designee will present the results of the audits to the Quality Assurance	

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S 560	Continued From page 2 1. For the week of Complaint staffing from 06/18/2023 to 06/24/2023, the facility was deficient in CNA staffing for residents on 5 of 7 day shifts as follows: -06/18/23 had 13 CNAs for 186 residents on the day shift, required at least 23 CNAs. -06/19/23 had 22 CNAs for 184 residents on the day shift, required at least 23 CNAs. -06/21/23 had 21 CNAs for 183 residents on the day shift, required at least 23 CNAs. -06/22/23 had 20 CNAs for 183 residents on the day shift, required at least 23 CNAs. -06/23/23 had 18 CNAs for 183 residents on the day shift, required at least 23 CNAs. 2. For the week of Complaint staffing from 07/02/2023 to 07/08/2023, the facility was deficient in CNA staffing for residents on 5 of 7 day shifts as follows: -07/02/23 had 23 CNAs for 190 residents on the day shift, required at least 24 CNAs. -07/03/23 had 21 CNAs for 188 residents on the day shift, required at least 23 CNAs. -07/04/23 had 22 CNAs for 187 residents on the day shift, required at least 23 CNAs. -07/06/23 had 22 CNAs for 187 residents on the day shift, required at least 23 CNAs. -07/07/23 had 22 CNAs for 187 residents on the day shift, required at least 23 CNAs. 3. For the week of Complaint staffing from 07/16/2023 to 07/22/2023, the facility was deficient in CNA staffing for residents on 4 of 7 day shifts as follows: -07/16/23 had 20 CNAs for 189 residents on the	S 560	Performance Improvement Committee will review and revise the plan if needed.	

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day shift, required at least 24 CNAs.
-07/17/23 had 18 CNAs for 189 residents on the day shift, required at least 24 CNAs.
-07/18/23 had 19 CNAs for 189 residents on the day shift, required at least 24 CNAs.
-07/20/23 had 22 CNAs for 195 residents on the day shift, required at least 24 CNAs.

4. For the week of Complaint staffing from 07/30/2023 to 08/05/2023, the facility was deficient in CNA staffing for residents on 5 of 7 day shifts and deficient in total staff for residents on 1 of 7 overnight shifts as follows:

-07/30/23 had 16 CNAs for 194 residents on the day shift, required at least 24 CNAs.
-07/31/23 had 20 CNAs for 193 residents on the day shift, required at least 24 CNAs.
-08/02/23 had 23 CNAs for 193 residents on the day shift, required at least 24 CNAs.
-08/03/23 had 14 CNAs for 193 residents on the day shift, required at least 24 CNAs.
-08/03/23 had 13 total staff for 193 residents on the overnight shift, required at least 14 total staff.
-08/04/23 had 14 CNAs for 195 residents on the day shift, required at least 24 CNAs.

5. For the week of Complaint staffing from 09/10/2023 to 09/16/2023, the facility was deficient in CNA staffing for residents on 1 of 7 day shifts as follows:

-09/11/23 had 22 CNAs for 187 residents on the day shift, required at least 23 CNAs.

6. For the 2 weeks of staffing prior to survey from 10/01/2023 to 10/14/2023, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	031601	A. BUILDING: _____ B. WING _____	C 10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLAS HEALTHCARE AT DAUGHTERS OF MIRIAM	155 HAZEL STREET CLIFTON, NJ 07011

(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) COMPLETE DATE
S 560	Continued From page 4 -10/01/23 had 19 CNAs for 190 residents on the day shift, required at least 24 CNAs. -10/02/23 had 20 CNAs for 190 residents on the day shift, required at least 24 CNAs. -10/03/23 had 22 CNAs for 190 residents on the day shift, required at least 24 CNAs. -10/04/23 had 22 CNAs for 190 residents on the day shift, required at least 24 CNAs. -10/05/23 had 22 CNAs for 190 residents on the day shift, required at least 24 CNAs. -10/06/23 had 20 CNAs for 190 residents on the day shift, required at least 24 CNAs. -10/07/23 had 20 CNAs for 190 residents on the day shift, required at least 24 CNAs. -10/08/23 had 20 CNAs for 190 residents on the day shift, required at least 24 CNAs. -10/09/23 had 20 CNAs for 190 residents on the day shift, required at least 24 CNAs. -10/10/23 had 20 CNAs for 191 residents on the day shift, required at least 24 CNAs. -10/11/23 had 20 CNAs for 191 residents on the day shift, required at least 24 CNAs. -10/12/23 had 20 CNAs for 191 residents on the day shift, required at least 24 CNAs. -10/13/23 had 20 CNAs for 191 residents on the day shift, required at least 24 CNAs. -10/14/23 had 20 CNAs for 191 residents on the day shift, required at least 24 CNAs.	S 560		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
031601	A. Building B. Wing	12/11/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLAS HEALTHCARE AT DAUGHTERS OF MIRIAM	155 HAZEL STREET CLIFTON, NJ 07011

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM (Y4)	DATE (Y5)	ITEM (Y4)	DATE (Y5)	ITEM (Y4)	DATE (Y5)
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 12/08/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 10/20/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315021	A. Building B. Wing	12/11/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLAS HEALTHCARE AT DAUGHTERS OF MIRIAM	155 HAZEL STREET CLIFTON, NJ 07011

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0609 Reg. # 483.12(b)(5)(i)(A)(B)(c)(1)(4) LSC	Correction Completed 12/08/2023	ID Prefix F0684 Reg. # 483.25 LSC	Correction Completed 12/08/2023	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
10/20/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO