STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315386	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLAS REHABILITATION AND HEALTHCARE AT MAYWOOD	100 WEST MAGNOLIA AVENUE , MAYWOOD, New Jersey, 07607

(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
F0000	INITIAL COMMENTS Complaint NJ#s: NJ#173987 and NJ#183724 Survey Date: 8/11/25 Census: 111 Sample: 23 sample + 3 closed records =26 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		08/19/2025
F0585 SS = E	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a	F0585	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS AFFECTED BY THE DEFICIENT PRACTICE On 8/11/25, Resident #4 and an unsampled resident were interviewed regarding the concern they expressed in the resident council meeting on 4/24/25. Resident #4 and the unsampled resident indicated that the facility resolved the concern in [NJ Ex Ord]. The Director of Maintenance (DOM) inspected the beds of Resident #4 and the unsampled resident and they were found to be in working condition. The Administrator updated the grievance forms to reflect the facility's intervention, and a copy of the grievance forms were offered to Resident #4 and the unsampled resident. On 8/11/25, Resident #117 was interviewed regarding the concern expressed in the resident council meeting on 4/24/25. According to Resident #117, the facility resolved the concern in [NJ Ex Ord]. The DOM inspected Resident #117's wheelchair and found it in working condition. The Administrator updated the grievance form to reflect the facility's intervention, and a copy of the grievance form was offered to Resident #117. On 8/12/25, Resident #4 was interviewed regarding the concern expressed in the resident council meeting on 5/29/25. According to Resident # 4 the facility addressed the concern in [NJ Ex Ord] and resident #4 is satisfied with the facility's response. The Director of Nursing (DON) updated the care plan to reflect Resident #4's preference. The Administrator updated the	09/12/2025

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: 315386	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/11/2025

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F0585 SS = E	Continued from page 1 copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;	F0585	Continued from page 1 grievance form and offered a copy to the resident which was declined. On 8/19/25, Resident #64 was interviewed regarding the concern expressed in the resident council meeting on 5/29/25. Resident #64 confirmed improvements to the concerns since NJ Ex Ord Resident #64's NJ Exec O was noted to be empty, and no meal tray was noted in the room. The DON updated resident #64's care plan to reflect preferences. The Administrator updated the grievance form and offered a copy which was declined. On 8/11/25, Resident #119 and Resident #28 were interviewed regarding the concern expressed in Resident Council meeting on 5/29/25. According to Resident #119 and Resident #28, the facility resolved the concern in NJ Ex Ord On 8/11/2025, the DOM inspected both wheelchairs and found the brakes in working condition. The administrator updated the grievance form and offered a copy to both residents, which they declined. On 8/11/25 Resident #32 was interviewed regarding the concern expressed in the resident council meeting held on 6/24/25. According to Resident #32, the facility addressed the concern in NJ Ex Ord On 8/11/25 Resident #4 was interviewed regarding the concern expressed in the resident council meeting held on 6/24/25. According to Resident #4 the facility addressed the concern in NJ Ex Ord On 8/11/25, the DOM inspected Resident #4's wheelchair and found it to be in working condition. The Director of Activities (DOA) updated the Resident Council Minutes for 4/2025, 5/2025, 6/2025, and 7/2025 to reflect the facility's follow up interventions and if concerns were rectified. HOW WILL THE FACILITY IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THIS SAME DEFICIENT PRACTICE All residents who express grievances have the potential to be affected by this deficient practice. WHAT MEASURES WILL BE PUT IN PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT OCCUR On 8/19/2025, the Regional Director of Clinical	

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F0585 SS = E	Continued from page 2 (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is NOT MET as evidenced by: Based on interview and review of facility documentation, it was determined that the facility failed to; a.) follow the facility's policy and procedure with regard to overseeing the grievance process, receiving, and tracking grievances through their conclusions; leading any investigations by the facility, b.) issue a written grievance decisions to the resident, and c.) ensure that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued. This deficient practice was identified for 3 of 3 resident council meetings ([redacted] and [redacted]). This deficient practice was evidenced by the following: On 8/6/25 at 3:11 PM, the surveyor reviewed the last three months resident council minutes that were provided by the [redacted], included but not limited to: -On [redacted] meeting, the maintenance concerns were two residents asked to have their [redacted] and one resident asked to have their wheelchair (w/c) looked at. -On [redacted] meeting, one resident would like to be [redacted]) more often and reported that not all staff were confident with using [redacted] to get the resident [redacted] Nursing to follow up. Another resident reported that they felt that meal were being picked up late and would like their [redacted] to be [redacted] There	F0585	Continued from page 2 Services (RDCS) in-serviced the [redacted]), and [redacted] on the facility's Resident Council Meeting Policy. On 8/19/25, the Administrator or designee in-serviced the department managers on the facility's Grievance and Resident Council Meeting Policy. The Administrator or designee audited the Resident Council minutes held in April, May, June, July, and August to ensure concerns requiring a written grievance, follow-up investigation, and care plan updates were addressed. Each week x 8 weeks, Administrator or designee will conduct an audit on grievances expressed by residents or family members to ensure all are investigated properly and written decisions are offered to the filing party. Following the first 8 weeks, this audit will be conducted monthly x 3 additional months. HOW WILL THE FACILITY MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR Audit results will be monitored by the Administrator at monthly QAPI meetings x 6 months to ensure compliance.	

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ATLAS REHABILITATION AND HEALTHCARE AT MAYWOOD	100 WEST MAGNOLIA AVENUE , MAYWOOD, New Jersey, 07607

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F0585 SS = E	Continued from page 3 were other two residents asked to have their w/c brakes looked at. -On [NJ Ex Order 26] meeting, residents reported day room doors had no handles on the inside, and that Maintenance would address it. There was one resident asked to have their w/c brake checked. Further review of the above resident council meeting minutes revealed that there were no documented evidence who were the identified residents who had concerns and issues. There were no documented evidence that the concerns were filed to grievance and resolution were notified, agreed by the residents. There were no documented evidence that the previous voiced concerns of the residents in the resident council meeting were discussed in the next meeting if resolution was reached and was rectified. On 8/7/25 at 8:38 AM, the surveyor asked again the [U.S. FOIA (] the names of the resident identified in the resident council minutes for nursing and other concerns, and she stated that she would get back to the surveyor. On 8/7/25 at 8:42 AM, the surveyor reviewed the Grievance binder for [NJ Ex Orde] and revealed: -there was no documented evidence for [NJ Ex Order 26] voiced concerns of the residents to reflect they were resolved or followed up. -there was no documented evidence for the [NJ Ex Order 26] voiced concerns of a resident with regard to their [NJ Ex Orde] and other residents' with w/c concerns were followed through, and resolution were accepted by the residents. -there was no documented evidence for [NJ Ex Order 26] voiced concerns of residents with regard to day room door handles and w/c to reflect they were resolved or followed up. On 8/7/25 at 9:00 AM, the [U.S. FOIA (] informed the surveyor that Resident #4 and Resident #64 were the residents who voiced out concerns on [NJ Ex Order 26.] resident council meeting. She added that Resident #4 was about the [NJ Ex Order 26.4(b)(1)] and [NJ Ex Ord] concerns while Resident #64 was about their [NJ Ex Order] The surveyor followed up the other residents' names for dates [NJ Ex Order 26] and [NJ Ex Order 26] who voiced out concerns in the resident council meetings,	F0585		

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F0585 SS = E	Continued from page 4 and the U.S. FOIA (b) (6) responded that she would get back to the surveyor. The U.S. FOIA (b) (6) was unable to provide further information and did not provide documentation as previously requested. On 8/7/25 at 9:02 AM, the U.S. FOIA (b) (6)) informed the surveyor that he attended resident council meetings, and it was the U.S. FOIA (b) (6) who was responsible for documenting residents' concerns during the meeting. The U.S. FOIA stated that if there were an issue on the said meeting, the U.S. FOI would send him a note in writing that resident council concerns pertaining to his department (Maintenance department). He further stated that the concerns of the residents during resident council were "official" if a note was given. On that same date and time, the surveyor asked the U.S. FOIA how the resident knew if the concerns with regard to maintenance issues were resolved and if it was documented. The U.S. FOIA stated that he relied on the maintenance book of each unit and if it was brought to the resident council, it was considered a problem to solve, and not an issue anymore. The U.S. FOIA acknowledged that there should be documentation for resolving grievance. The surveyor notified the above findings and concerns that there were no documented evidence that the concerns on resident council meetings concerning maintenance department was resolved and followed up. On 8/7/25 at 9:19 AM, the surveyor interviewed the U.S. FOIA who informed the surveyor that she had been working in the facility for years. The U.S. FOI stated that as facility's practice and process, during resident council meeting, she was responsible for documenting and emailing to all department heads the minutes of the meeting. She further stated that she utilized a form where to document the voiced concerns of the residents during the meeting and handed them to each department heads if the concerns were according to their department. The U.S. FOI also stated that after the department head followed up and took action for the voiced concerns, the department head will fill up and sign that form that she provided, will return to the U.S. FOI the filled up form, and "I" will acknowledge, review, and signed off as well. She added that she have a binder for all of them as she was the gate keeper. She also stated that she was responsible for tracking and record keeping of all resident council meeting concerns of residents.	F0585		

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F0585 SS = E	Continued from page 5 On that same date and time, the U.S. FOI went to her office and showed to the surveyor the binder for the Resident Council Response Form (RCRF) and revealed: -for NJ Ex Order 26.4(b), there were RCRF for NJ Ex Order 26, that included Maintenance Department with Department Response: all issues resolved. Further review of the RCRF dated NJ Ex Order 26, revealed, there were no names to identify residents and what was fixed. The surveyor asked the U.S. FOI who was the resident identified in the resolved issues, and the U.S. FOI responded that it was Resident #96. Upon review of the provided NJ Ex Order 26 resident council meeting attendees, Resident #96 did not attend the meeting. The surveyor asked the U.S. FOI if it was resolved for Resident #96, and why the resident was not even present in the meeting. The NJ Ex O then responded that she think it was Resident #117, and not Resident #96. -for NJ Ex Order 26.4(b, the Resident Council Response Form Checklist for the Maintenance department was blank. There was no RCRF to address the NJ Ex Order 26.4 maintenance and care issue for meals and NJ Ex Orde concerns of the residents who voiced out their concerns. The surveyor asked the U.S. FOI why there was no NJ Ex Order 26.4 RCRF for the concerns of two residents with regard to their w/c and resident who had concern with their meals and NJ Ex Order and the U.S. FOI responded that even there was no form, it did not mean that it was not rectified. The surveyor asked the U.S. FOI who were the residents for the w/c concerns, and she stated that it was Resident #119, and "I believe" the other one was Resident #28. The surveyor asked the U.S. FOI as to why there was no documented evidence or RCRF initiated for the NJ Ex Order 26 concerns if that was the facility's practice and process, and the U.S. FOI stated, "I have no answer for that." On 8/7/25 at 9:46 AM, the surveyor interviewed the U.S. FOIA (b) who stated that the facility's process for the resident council was that meeting done once a month. The U.S. FOIA (further stated that residents verbalized either positive and negative comments, and it was the U.S. FOIA (responsibility to give the response form to each department, if immediate "like" the maintenance issues, it would be addressed the same day. At that same time, the surveyor notified the U.S. FOIA (of the above findings and concerns about Resident#64's	F0585		

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F0585 SS = E	Continued from page 6 concerns with NJ Ex Orde had no documented evidence that grievance was done, followed up, resolution was reached, and resident agreed according to the facility's process and practice. The U.S. FOIA (b) did not provide additional information. On 8/7/25 at 10:30 AM, the surveyor met with the four residents for resident council meeting. Resident #32 stated that on NJ Ex Order 26.4 council meeting, it was the day rooms in 2nd and 3rd floor handles were fixed within a week by U.S. FOIA Resident #32 further stated that they knew it was fixed within a week from their report because there were handles in the day room doors already. The resident acknowledged that there was no formal report or resolution provided to the resident about it. On 8/7/25 at 1:35 PM, the survey team met with the U.S. FOIA (b and U.S. FOIA (b) (6)), and the surveyor asked the U.S. FOIA (b and U.S. FOIA if they consider the resident's concerns mentioned in the resident council meetings were a form of a grievance, and both the U.S. FOIA (b and U.S. FOIA had no answer. At that same time, the surveyor notified the concerns about resident council meetings, that the facility did not follow the facility's procedure with regard to overseeing the grievance process, receiving, and tracking grievances through their conclusions as per interview with the U.S. FOIA as a gatekeeper; leading any investigations by the facility, ensure that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, and a summary of the pertinent findings or conclusions regarding the resident's concerns. The U.S. FOIA (b and U.S. FOIA did not provide additional information. On 8/8/25 at 10:52 AM, the surveyor interviewed Resident #64 inside their room while seated on the bed NJ Ex Order 26.4(b)(1) at that time, with NJ Ex Order [redacted] and wheelchair at the bedside. The resident claimed that they attended the resident council meeting on NJ Ex Order 26, and voiced out concern that the staff were not NJ Ex Order 26.4(b)(1) timely, and had to wait at times even though they called for assistance. The resident also stated that no one had come to tell them what the resolution for the concern was, but they knew it was getting better, and staff had been coming to their room to NJ Ex Order 26.4(b)(1) promptly, which they noticed in the 1st week of NJ Ex Order 26.4(b)	F0585		

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F0585 SS = E	Continued from page 7 On 8/8/25 at 12:53 PM, the survey team met with the U.S. FOIA (b) (6) and U.S. FOIA and the U.S. FOIA (b) (6) . The U.S. FOIA (b) (6) stated that the U.S. FOI had been at the facility for NJ Ex Order 26.4(b)(1) and that the U.S. FOIA and the U.S. FOIA had their own follow up documentation for the resident council voiced residents' concerns. The U.S. FOIA (b) (6) further stated that the handle for the doors in the day rooms were fixed as soon as possible and was in the maintenance log. The U.S. FOIA (b) U.S. FOIA and U.S. FOIA (b) (6) were unable to provide documented evidence was filed and done for w/c concerns. At that same time, the surveyor asked the U.S. FOIA and U.S. FOIA as to why there was no documented evidence that grievance was filed, followed up, and resolution was relayed to identified residents for the above mentioned concerns when the surveyor had asked for it, and the U.S. FOIA had no answer. Furthermore, the surveyor also notified the concerns with resident council that the facility did not issue a written grievance decisions to the resident as confirmed by Resident#64 and to other residents who had voiced out concerns with their w/c, and a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued. Resident #64 also mentioned that the resident knew that it was getting better, that the staff had been prompt with going to resident's room to NJ Ex Order 26.4(b)(1) on 1st week of NJ Ex Order 26.4(b), for the NJ Ex Order 26 concerns that they voiced out. A review of the provided Service Requestor Log (SRL) from NJ Ex Order 26.4 to NJ Ex Order 2 that was provided by the U.S. FOIA revealed a highlighted information for the following dates: - NJ Ex Order 26, requestor: U.S. FOIA (b) (6) , location of need: rooms NJ Ex Orde and NJ Ex Orde correction request of need: w/c broke needs to be fixed, correction date: NJ Ex Or, and correction by: U.S. FOIA - NJ Ex Order 26, requestor: unidentified staff, location of need: dayrooms, correction request of need: missing door handles on inside of doors, correction date: NJ Ex Orde and correction by: U.S. FOIA	F0585		

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F0585 SS = E	Continued from page 8 Further review of the above provided SRL revealed that there was no documented evidence that the resident's concern on [redacted] for w/c was identified in the log. The [redacted] did not provide a copy of SRL for [redacted] A review of the provided Grievance/Concern Form (G/CF) dated [redacted] (typewritten) that was signed by the [redacted] was incomplete. The attached Summary of Investigation that was signed by the [redacted] was incomplete. The attached Summary of Investigation and the G/CF were not in the [redacted] Grievance binder that was previously provided on [redacted] The attached Summary of Investigation Summary and the G/CF were not provided on [redacted] at 3:11 PM when the surveyor asked for the resident council minutes for the last three months not until [redacted] at 12:55 PM. On 8/11/25 at 8:45 AM, the surveyor interviewed the [redacted] regarding the facility's process with resident council meeting and grievances. The [redacted] stated that it would be each department's responsibility to follow up with resident's concerns in the resident council meeting. The [redacted] stated that the concerns voiced out in the resident council meeting was considered form of grievance and should be filed and resolved. The [redacted] also stated that if the resident's concerns were about care issues like resident's [redacted] or [redacted] care, care plan should be updated or revised to reflect the resolution in the grievance and acknowledge the resident's care preferences. At that same time, the surveyor notified the [redacted] of the above findings and concerns that Resident #64's [redacted] concerns were not followed through in timely manner and the resolution was notified to the resident. The surveyor also notified the [redacted] of the concerns that there were discrepancy on the facility's IDT (interdisciplinary team) process to follow on how the grievance was filed and handled. The [redacted] stated that moving forward "we will put our process more united." A review of the facility's "Grievances/Complaints, Filing Policy" that was provided by the [redacted] with a revision date of April 2017, revealed, under Policy Statement: residents and their representatives have the right to file grievances, either orally or in writing, to the facility staff or to the agency designated to hear grievances. The administrator and staff will make prompt efforts to resolve grievances to the	F0585		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315386	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLAS REHABILITATION AND HEALTHCARE AT MAYWOOD	100 WEST MAGNOLIA AVENUE , MAYWOOD, New Jersey, 07607

(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
F0585 SS = E	Continued from page 9 satisfaction of the resident and/or representative. Under Policy Interpretation and Implementation:.. 3. All grievances, complaints or recommendations stemming from resident or family groups concerning issues of resident care in the facility will be considered. Actions on such issues will be responded to in writing, including a rationale for the response.... On 8/11/25 at 1:00 PM, the survey team met with the U.S. FOIA (b) U.S. FOIA (U.S. FOIA (b) (6 and the U.S. FOIA (b) (6) for an exit conference. The U.S. FOIA (and U.S. FOIA did not provide additional information and did not refute the findings. NJAC 8:39-4.1(a)5, 12; 13.2(c)	F0585		
F0628 SS = D	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.	F0628	1. WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS AFFECTED BY THE DEFICIENT PRACTICE On 8/7/2025, Resident #130, who no longer resides in the facility, was added to the NJ Ex Order 26.4(b)(1) Log and same was faxed to the Ombudsman. The Emergency Transfer Notice was uploaded in resident #130 electronic health record. 2. HOW WILL THE FACILITY IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THIS SAME DEFICIENT PRACTICE All residents transferred or discharged from the facility have the potential to be affected. 3. WHAT MEASURES WILL BE PUT IN PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT OCCUR On 8/19/25, the Administrator educated the social workers on the facility's Transfer or Discharge Notice Policy to ensure accurate completion of the Emergency Transfer Notice, the monthly notification of the facility's emergency transfers and discharges to the Ombudsman, and to upload the Emergency Transfer Notice in the resident's electronic health record. The Social Worker (SW) audited the emergency transfers and discharges in the month of August to ensure emergency transfer notices were completed, copy provided to the resident and family representative,	10/8/2025

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLAS REHABILITATION AND HEALTHCARE AT MAYWOOD	100 WEST MAGNOLIA AVENUE , MAYWOOD, New Jersey, 07607

(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
F0628 SS = D	Continued from page 10 §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written	F0628	Continued from page 10 sent to the Ombudsman, and uploaded in the resident's electronic health record. The Business Office Manager (BOM) or designee will audit all notices of Emergency Transfers and Discharges every month x 3 months The BOM or designee will audit the monthly notification log to the Ombudsman for accuracy every month x 3 months. 4. HOW WILL THE FACILY MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR The BOM will report the results of the audit at monthly QAPI meetings x 3 months to ensure compliance and if further action is necessary.	

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F0628 SS = D	Continued from page 11 notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the	F0628		

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F0628 SS = D	Continued from page 12 State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to	F0628		

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F0628 SS = D	Continued from page 13 authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review and review of other pertinent facility documents, it was determined that the facility failed to provide a copy of the resident and the resident's representative's written notification of the reason for NJ Ex Order 26 to NJ Ex Order 26.4(b)(1) to a representative of the Office of the State U.S. FOIA (b) (6)) for 1 of 2 resident's (Resident #130) reviewed for hospitalization. This deficient practice was evidenced by the following: A review of Resident #130's closed electronic medical record included the following: Resident #130's discharge return anticipated Minimum Data Set's (DRAMDS), an assessment tool used to facilitate the management of care, reflected that the resident was transferred to the hospital. A review of the medical record did not include a written notification of the reason for NJ Ex Order 26 to the resident or resident representative and a copy to the U.S. FOIA (for the NJ Ex Order 26 to the hospital uploaded into the electronic medical record. On 8/7/25 at 10:24 AM, the surveyor interviewed the U.S. FOIA (b) (6)) regarding the process for written notification for NJ Ex Order 26 to the hospital and notification to the U.S. FOIA (b The U.S. FOIA (stated when she gets the update from nursing that a resident was NJ Ex Order 26.4(b)(1 to NJ Ex Order 26.4(b)(1) she will fill out the Notice of NJ Ex Order 26. or Discharge form. The U.S. FOIA (stated that the form was mailed out to the family and that they kept a copy in a binder. The U.S. FOIA (stated that in the front of the binder there was a log for each month that they updated with the resident NJ Ex Order 26 information and that the log was emailed to the ombudsman once a month. On 8/7/25 at 1:00 PM, the surveyor reviewed the facility provided emergency NJ Ex Order 26 binder and Resident #130's Notice of NJ Ex Order 26. or Discharge form was not in the binder and Resident #130 was not listed on the NJ Ex Order 26.4(b)(1) log that was sent to the U.S. FOIA (b	F0628		

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F0628 SS = D	Continued from page 14 On 8/7/25 at 2:18 PM, the U.S. FOIA (confirmed that Resident #130 was not listed on the log that went to the ombudsman and that a copy of Resident #130's Notice of NJ Ex Order 26 or Discharge that was sent to the family was also not in the binder. The U.S. FOIA (stated that she "remember a backstory" and that she would let the surveyor know the next day the reason the form was not in the binder. On 8/8/25 at 9:16 AM, the U.S. FOIA (stated that she believed that they were looking at the form for some reason and that she found the form in a "soft file." The U.S. FOIA (stated that she mailed out the notice to the family but that the U.S. FOIA (was not notified because Resident #130 was not written on the log. On 8/8/25 at 1:54 PM, the surveyor notified the U.S. FOIA (b) (6)), U.S. FOIA (b) (6)) and U.S. FOIA (b) (6)) the concern that a copy of Resident #130's Notice of NJ Ex Order 26 or Discharge was not provided to the U.S. FOIA (b On 8/11/25 at 11:43 AM, in the presence of the U.S. FOIA and U.S. FOIA (b) (6) the U.S. FOIA (stated that they performed an audit for notification to the ombudsman and that there were no further resident's transfers that were not sent to the U.S. FOIA (b The U.S. FOIA (did not provide any additional information. A review of the facility's "Transfer or Discharge Notices" with a revised date of March 2025, included the following: Policy Statement Residents (or resident representatives) are notified of an impending transfer or discharge and the reasons for the move in writing and in a language and manner they understand. A copy of the notice is sent to the Office of the State Long-Term Care Ombudsman. Policy Interpretation and Implementation Notice of Transfer or Discharge (Emergency) 1. When a resident is sent emergently to an acute care setting, this is considered a transfer, not discharge, because the resident's return is generally expected. 2. Notice of Transfer is provided to the resident and or representative as soon as practicable before the transfer and to the long-term care (LTC) ombudsman when	F0628		

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ATLAS REHABILITATION AND HEALTHCARE AT MAYWOOD	100 WEST MAGNOLIA AVENUE , MAYWOOD, New Jersey, 07607

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F0628 SS = D	Continued from page 15 practicable (e.g., in a monthly list of residents that includes all notice content requirements). N.J.A.C. 8:39-4.1(a)31,32	F0628		
F0636 SS = E	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures.	F0636	1. WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS AFFECTED BY THE DEFICIENT PRACTICE The comprehensive Minimum Data Set (cMDS) assessment for Residents # 15 was completed on NJ Ex Order 26.4(b) The cMDS assessment for Resident # 17 was completed on NJ Ex Order 26.4(b)(The cMDS assessment for Resident #61 was completed on NJ Ex Order 26.4(The cMDS assessment for Resident #74 was completed on NJ Ex Order 26.4(b)(The cMDS assessment for Resident # 92 was completed on NJ Ex Order 26.4(b)(2. HOW WILL THE FACILITY IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THIS SAME DEFICIENT PRACTICE All residents who require a cMDS assessment have the potential to be affected by this deficient practice. 3. WHAT MEASURES WILL BE PUT IN PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT OCCUR On 8/11/2025, the facility educator in-serviced the U.S. FOIA (b) (6) on completing a comprehensive assessment within 14 calendar days of the resident's admission. The Regional Minimum Data Set Director (RMDSD)or designee audited all August cMDS assessments currently due for completion to ensure timely completion. The MDS Coordinator or designee will audit all cMDS assessments for timely completion weekly x 4 weeks then monthly x 3 months to ensure compliance. 4. HOW WILL THE FACILY MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR	08/18/2025

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F0636 SS = E	Continued from page 16 (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is NOT MET as evidenced by: Based on the interview and record review, it was determined that the facility failed to complete the comprehensive Minimum Data Set (MDS) assessment in accordance with the Resident Assessment Instrument (RAI) manual and facility policy for 6 of 6 (Residents #15, #17, #61, #74, #92, and #105) residents reviewed for comprehensive resident assessments. This deficient practice was evidenced by the following: Reference: Centers For Medicare and Medicaid Services (CMS), RAI manual, Version 3.0, last revised in October 2024 indicated in Chapter 2, pages 2-8 to 2-9 revealed: …Admission refers to the date a person enters the facility and is admitted as a resident. A day begins at 12:00 AM (12 AM) and ends at 11:59 PM. Regardless of whether admission occurs at 12 AM or 11:59 PM, this date is considered the 1st day of admission. Completion of an OBRA…Under Chapter 2, Section 2.6-Required OBRA [Omnibus Budget Reconciliation Act] Assessments for the	F0636	Continued from page 16 The Administrator or designee will report the results of the audits at monthly QAPI meetings x 4 months to ensure compliance and if further action is necessary.	

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F0636 SS = E	Continued from page 17 MDS revealed:…MDS Completion Date (Item Z0500B) No Later Than… 14th calendar day of the resident's admission (admission date + 13 calendar days) …The Admission assessment is a comprehensive assessment for a new resident and, under some circumstances, a returning resident that must be completed by the end of day 14, counting the date of admission to the nursing home as day 1if…this is the resident's first time in this facility, OR…the resident has been admitted to this facility and was discharged return not anticipated, or…the resident has been admitted to this facility and was discharged return anticipated and did not return within 30 days of discharge.…Federal statute and regulations require that residents are assessed promptly upon admission (but no later than day 14) and the results are used in planning and providing appropriate care to attain or maintain the highest practicable well-being. This means it is imperative for nursing homes to assess a resident upon the individual's admission. The IDT may choose to start and complete the Admission comprehensive assessment at any time prior to the end of day 14... The surveyor reviewed the system selected resident assessments which revealed the following: A review of Resident #15's comprehensive MDS (cMDS) with assessment reference date (ARD) of NJ Ex Order 26.4 revealed that the MDS was dated and signed as complete on NJ Ex Order 26. The MDS assessment was completed more than 14 days after the admission date. A review of Resident #17's cMDS with an ARD of NJ Ex Order 26. revealed that the MDS was dated and signed as complete on NJ Ex Order 26.4 The MDS was completed more than 14 days after the admission date. A review of Resident #61's cMDS with an ARD of NJ Ex Order 26., revealed that the MDS was dated and signed as complete on NJ Ex Order 26 The MDS was completed more than 14 days after the admission date. A review of Resident #74's cMDS with an ARD of NJ Ex Order 26. revealed that the MDS was dated and signed as complete on NJ Ex Order 26.4 The MDS was completed more than 14 days after the admission date. A review of Resident #92's cMDS with an ARD of NJ Ex Order 26. revealed that the MDS was dated and signed as complete on NJ Ex Order 26. The MDS was completed more than 14 days after the admission date. On 8/6/25 at 9:55 AM, the surveyor interviewed the U.S. FOIA (b) (6)), who stated	F0636		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLAS REHABILITATION AND HEALTHCARE AT MAYWOOD	100 WEST MAGNOLIA AVENUE , MAYWOOD, New Jersey, 07607

(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
F0636 SS = E	Continued from page 18 that the cMDS assessment should be completed one to two weeks after creating it and it should be submitted one to two weeks after the MDS assessment was completed. The U.S. FOIA (b) (6) stated she was responsible for ensuring completion and accuracy of the MDS assessments. The surveyor requested the final validation report for Resident #15, #18, #61, #74, and #92 as there were concerns with their MDS assessments. On 8/6/25 at 11:25 AM, the U.S. FOIA (b) (6) provided the MDS final validation report which was dated 8/6/25. The U.S. FOIA (b) (6) acknowledged late completion of the MDS assessments. On 8/6/25 at 11:34 AM, the U.S. FOIA (b) (6) informed the surveyor the cMDS should be completed by 14 days after the resident's admission. The U.S. FOIA (b) (6) further explained if there was anything pending or needed to be looked into for the resident's assessment, the MDS might be late. On 8/7/25 at 1:41 PM the surveyor notified the U.S. FOIA (b) (6) and the U.S. FOIA (b) (6) regarding the concern of late MDS completion for Residents' # 15, #17, #61, #74, and #92. On 8/8/25 at 12:53 PM, the U.S. FOIA (b) U.S. FOIA and U.S. FOIA (b) (6) met with the survey team. The U.S. FOIA (acknowledged the MDS assessments were completed late and that they had no additional information to provide the surveyor. On 8/11/25 at 8:40 AM, an additional review for Resident #105's cMDS with an ARD of NJ Ex Order 2 , revealed that the MDS was dated and signed as complete on NJ Ex Order 2 . The MDS was completed more than 14 days after the admission date. On 8/11/25 at 11:43 AM, the surveyor notified the U.S. FOIA (b) U.S. FOIA and U.S. FOIA (b) (of the concern for late completion of Resident #105's admission assessment. The facility did not provide any additional information. A review of the facility's "Comprehensive Assessments Policy" with a revised date of March 2022, under Policy Interpretation and Implementation revealed: 1. Comprehensive assessments are conducted in accordance with criteria and timeframes established in the RAI User Manual. 2. Admission Assessment- The Admission assessment is a comprehensive assessment for a new resident and, under some circumstances, a returning resident that must be completed by the end of day 14, counting the date of admission to the nursing home as day 1 if: a. this is the resident's first time in this	F0636		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315386	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLAS REHABILITATION AND HEALTHCARE AT MAYWOOD	100 WEST MAGNOLIA AVENUE , MAYWOOD, New Jersey, 07607

(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
F0636 SS = E	Continued from page 19 facility, b. the resident had been admitted to this facility and was discharged return not anticipated, c. the resident has been admitted to this facility and was discharged return anticipated and did not return within 30 days of discharge… A review of the facility's "Electronic Transmission of the MDS Policy" with a revised date of October 2023, under Policy Statement revealed:…All MDS assessments…and discharge and reentry records are completed and electronically encoded into the facility's MDS information system and transmitted to the CMS' Internet Quality Improvement and Evaluation System (IQIES) system in accordance with current OBRA regulations governing the transmission of MDS data…Under Policy Interpretation and Implementation revealed:…1. All staff members responsible for completion of the MDS receive training on the assessment, data entry, and transmission processes, in accordance with the Resident Assessment Instrument (RAI) User's Manual, before being permitted to use the MDS information system… NJAC 8:39-11.1, 11.2(e)(h)	F0636		
F0640 SS = D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System	F0640	1. WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS AFFECTED BY THE DEFICIENT PRACTICE The Discharge Return Anticipated MDS (DRAMDS) assessment for Resident #11 was completed and transmitted on [redacted] 2. HOW WILL THE FACILITY IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THIS SAME DEFICIENT PRACTICE All residents discharged from the facility have the potential to be affected by this deficient practice. 3. WHAT MEASURES WILL BE PUT IN PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT OCCUR On 8/11/2025, the facility educator in-serviced the [redacted] on the facility's "Electronic Transmission of the MDS Policy" and the timely transmission of the assessments. The Regional MDS Director or designee audited all August DRAMDS assessments currently due for	08/11/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315386	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/11/2025

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F0640 SS = D	Continued from page 20 information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review and review of pertinent facility documentation, it was determined that the facility failed to submit the Minimum Data Set (MDS) assessments in a timely manner for 1 of 2 residents reviewed for NJ Ex Order 26.4(b)(1) (Resident #11). The deficient practice was evidenced by the following: On 8/7/25 at 11:42 AM, the surveyor reviewed the closed medical record of Resident #11. A review of the Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included	F0640	Continued from page 20 transmission to ensure timely transmission. The Regional MDS Director or designee will audit all DRAMDS assessments due for transmission weekly x 4 weeks, then monthly x 3 months to ensure compliance. 4. HOW WILL THE FACILY MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR The Administrator or designee will report the results of the audits at monthly QAPI meetings x 4 months to ensure compliance and if further action is necessary.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315386	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/11/2025

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F0640 SS = D	Continued from page 21 but were not limited to; NJ Ex Order 26.4(b)(1) [redacted]), NJ Ex Order 26.4(b)(1) [redacted]) and NJ Ex Order 26.4(b)(1) [redacted]). A review of Resident #11's Universal Transfer Form (UTF), a communication form used when a resident is NJ Ex Order 26.4(b)(1) indicated that the resident was NJ Ex Order 26.4(b)(1) to NJ Ex Order 26.4(b)(1) on NJ Ex Order 26.4(b)(1). A review of Resident #11's Progress Note indicated that the resident was NJ Ex Order 26.4(b)(1) to NJ Ex Order 26.4(b)(1) on NJ Ex Order 26.4(b)(1). There was no additional note that the resident had returned to the facility. A review of Resident #11's last MDS, an assessment tool used to facilitate the management of care, indicated that the MDS was an interim payment with an ARD of NJ Ex Order 26.4(b)(1). There was NJ Ex Order 26.4(b)(1) Anticipated MDS (NJ Ex Order 26.4(b)(1) with an ARD of NJ Ex Order 26.4(b)(1) in the electronic medical record for the resident's NJ Ex Order 26.4(b)(1) to NJ Ex [redacted]. On 8/7/25 at 11:54 AM, the surveyor interviewed the U.S. FOIA [redacted] regarding the MDS process when a resident was NJ Ex Order 26.4(b)(1) to NJ Ex Order 26.4(b)(1). The U.S. FOIA (b) stated that if a resident is NJ Ex Order 26.4(b)(1) to NJ Ex [redacted] she would review the progress notes and go into the MDS portal put in a discharge MDS and the type depended on insurance whether it was a NJ Ex Order 26.4(b)(1) [redacted] or a NJ Ex Order 26.4(b)(1) Not Anticipation. The U.S. FOIA (b) stated that there is a timeframe for when it was due for completion and submission but that she would have to check on the specifics. On 8/7/25 at 1:07 PM, NJ Ex Order 26.4(b)(1) stated that a Discharge MDS would be opened the next day after NJ Ex Order 26.4(b)(1). She added that it would be completed within 14 days of opening and submitted within 14 days of completion. On 8/7/25 at 1:11 PM, the U.S. FOIA (b) confirmed that Resident #11 did not have a NJ Ex Order 26.4(b) done and that it should have been. On 8/7/25 at 1:42 PM, the surveyor notified the U.S. FOIA (b) (6) [redacted]), U.S. FOIA (b) (6) [redacted]) and U.S. FOIA (b) (6)	F0640		

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ATLAS REHABILITATION AND HEALTHCARE AT MAYWOOD	100 WEST MAGNOLIA AVENUE , MAYWOOD, New Jersey, 07607

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F0640 SS = D	Continued from page 22 U.S. FOIA (b) (6)) the concern that Resident #11 did not have a NJ Ex Order 26.4(b)(1) On 8/8/25 at 1:00 PM, in the presence of the U.S. FOIA and U.S. FOIA (b) (6) the U.S. FOIA (b) stated that the U.S. FOIA (b) completed Resident #11's NJ Ex Order 26.4(b) after surveyor inquiry. The U.S. FOIA (b) (6) stated that the U.S. FOIA (b) was new and that she had started a QAPI (quality assurance performance improvement) on late completion. The U.S. FOIA (b) did not provide any additional information. A review of the facility's "Electronic Transmission of the MDS Policy" with a revised date of October 2023, included the following: All MDS assessments…and discharge and reentry records are completed and electronically encoded into the facility's MDS information system and transmitted to the CMS' Internet Quality Improvement and Evaluation System (IQIES) system in accordance with current OBRA (Omnibus Budget Reconciliation Act (OBRA), also known as the Nursing Home Reform Act of 1987, has dramatically improved the quality of care in the nursing facility) regulations governing the transmission of MDS data. N.J.A.C. 8:39-11.2	F0640		
F0658 SS = D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to consistently document resident refusal for daily NJ Ex Order 26 and notify the physician regarding the resident's NJ Exec Orde for 1 of 26 residents (Resident #77) reviewed. This deficient practice was evidenced by the following: On 8/5/25 at 10:26 AM, the surveyor observed Resident #77, lying in bed, NJ Ex Or and NJ Ex Order 26.4(b)(1) The	F0658	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THE RESIDENTS AFFECTED BY THE DEFICIENT PRACTICE On 8/7/25, late entry notes were entered by the RN/UM in Resident #77's progress notes related to NJ Exec Orde of daily NJ Ex Order 26 from NJ Ex Order 26.4(b)(1), and on NJ Ex Order 26 The provider was notified of the refusal to be NJ Ex Order 26.4 daily. Resident #77 was assessed by the US FOIA (b)(6) who educated the resident on the importance of monitoring NJ Ex Order 2 HOW WILL THE FACILITY IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THIS SAME DEFICIENT PRACTICE All residents with orders for daily weights have the potential to be affected by this deficient practice. WHAT MEASURES WILL BE PUT IN PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT	09/08/2025

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F0658 SS = D	Continued from page 23 resident was being attended to by a US FOIA (b)(6) . On 8/6/25 at 10:25 AM, the surveyor reviewed the paper chart and the Electronic Medical Record (EMR) of Resident #77. A review of the Admission Record (an admission summary) documented Resident #77 had diagnoses that included but were not limited to; NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1) , and NJ Ex Order 26.4(b)(1) . A review of the comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of NJ Ex Order , reflected a Brief Interview Mental Status (BIMS) score of NJ E out of 15, which indicated the resident had NJ Ex Order 26.4(b)(1) . A review of the physician's order dated NJ Ex Order 26.4 daily NJ Ex Order 26 for NJ Ex Order 26.4(b)(1)] in the morning, document NJ Ex Order 26. A review of the documented NJ Exec Order for Resident #77 revealed the following: - NJ Ex Order 26.4(b)(1) .) - NJ Ex Order 26.4(b)(1) A review of the NJ Ex Order 26.4(b) electronic Treatment Administration Record (eTAR) revealed the nurses signed on NJ Ex Order 26 , NJ Ex Order 26 , NJ Ex Order 26 , NJ Ex Order 26 , NJ Ex Order 26.4 NJ Ex Order 26 , NJ Ex Order 26 , and NJ Ex Order 26 for the daily NJ Ex Order 26 being completed. Or NJ Ex Order 26. and NJ Ex Order 26 the entries were blank. A review of the NJ Ex Order 26.4(b)(1) eTAR revealed the nurses signed on NJ Ex Order to NJ Ex Order 2 for the daily NJ Ex Order 26 being completed. There were no documented NJ Ex Order 26 within the entry. A review of NJ Ex O and NJ Ex Order 26.4(b)(1) progress notes revealed the nurses documented the resident refused daily NJ Ex Order 26 on the following dates: NJ Ex Order 26. , NJ Ex Order 26. , NJ Ex Order 26 , NJ Ex Order 26 , NJ Ex Order 26 , and NJ Ex Order 2 There was no documentation of a NJ Ex Order or NJ Exec Orde for the dates of the resident's daily NJ Ex Order being signed as completed. There was no documentation indicating the	F0658	Continued from page 23 OCCUR The facility educator in-serviced licensed nursing personnel and certified nursing assistants (CNA) on the facility's Weight Policy. The Dietician or designee audited all active residents with daily weight orders to ensure weights are obtained or MD was made aware of refusals. The Dietician or designee will review active residents with orders for daily weights during clinical meeting. The Dietician or designee will audit all residents with orders for daily weights for completion weekly x 1 month then monthly x 3 months to monitor for compliance. HOW WILL THE FACILY MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR The Dietician or designee will report the results in monthly QAPI meetings x 4 months to ensure compliance and if further action is needed.	

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F0658 SS = D	Continued from page 24 physician was notified about the resident [NJ Exec Order 2] daily [NJ Ex Order 26] to be done. On 8/6/25 at 11:57 AM, the surveyor interviewed the [US FOIA (b)(6)] about [NJ Ex Order 26.] [US FOIA] stated CNAs would obtain residents' [NJ Ex Order 26] and assigned which [NJ Ex Order 26] for residents to obtain. The [US FOIA] further explained that after obtaining the [NJ Ex Order 2] the [US FOIA] would notify the nurse who would document the [NJ Ex Order 2] The surveyor asked the [US FOIA] what would happen if the resident refused to [NJ Ex Order 26.4(b)(1)]. The [US FOIA] replied that the nurse would be notified, and the nurse would document the [NJ Exec Order] On 8/6/2025 at 12:16 PM, the surveyor interviewed the Licensed Practical Nurse #1 (LPN#1) about obtaining residents' [NJ Ex Order 26.] LPN#1 stated the CNAs obtained residents' [NJ Ex Order 26] who informed the nurses about the result of [NJ Ex Order 26] obtained. LPN#1 explained the nurses would document the results in the [NJ Ex Order 26.4(b)(1)] section of the EMR and there was a [NJ Ex Order] binder at the nurses' station. LPN#1 further stated that resident [NJ Exec Orde] would be documented in the EMR. On 8/6/25 at 12:20 PM, the surveyor interviewed LPN#2 about obtaining [NJ Ex Order 26.] LPN#2 confirmed there was a [NJ Ex Order] binder that listed monthly and weekly [NJ Ex Order 26] that needed to be obtained. LPN#2 further explained [NJ Ex Order 26] were completed according to the list in the binder; nurses documented in the EMR the results and the [U.S. FOIA (b) (6)] reviewed the [NJ Ex Order 26] obtained. The surveyor asked LPN#2 about daily [NJ Ex Order 26.] LPN#2 stated daily [NJ Ex Order 26] were ordered by the physician and was found under physician's orders and the eMAR (electronic Medication Administration Record). LPN#2 explained the nurse would document the [NJ Ex Order] directly into the eMAR. On that same date and time, the surveyor asked LPN#2 what was done if a resident refused to [NJ Ex Order 26.4(b)(1)]. LPN#2 replied that it would be documented in the EMR that the resident refused to be [NJ Ex Order 26.4(] LPN#2 added that she would attempt multiple times, encourage and educate the resident on the benefits of obtaining daily [NJ Ex Order 26.] On 8/6/25 at 12:26 PM, the surveyor interviewed the [U.S. FOIA (b) (6)] about obtaining daily [NJ Ex Order 26.] The [U.S. FOIA (b) (] stated daily [NJ Ex Order 26] were ordered and found in the eMAR. The [U.S. FOIA (b)] explained the	F0658		

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F0658 SS = D	Continued from page 25 nurses documented the NJ Ex Order in the EMR and if the resident refused the nurses would document the resident's refusal and notify the physician. The surveyor asked the U.S. FOIA (b) how soon was if expected for the nurse to notify the physician that a resident was refusing daily NJ Ex Order 26 The U.S. FOIA (b) (6 replied that once a resident refused the first time the nurse should notify the physician. The surveyor discussed with the U.S. FOIA (b) the concern regarding the above concerns for Resident #77's daily NJ Ex Order documentation and there was no documentation to indicate the nurse notified the physician of the resident having NJ Exec Order 26 of NJ Exec Order 2 daily NJ Ex Order 26. On 8/7/25 at 9:50 AM, the U.S. FOIA (b) informed the surveyor that she followed up regarding Resident #77's daily NJ Ex Order 26 and provided education to staff about documentation of NJ Ex Order 26 and NJ Ex Order NJ Exec Order 2 The U.S. FOIA (b) stated the nurses were to code in the eMAR when the resident refused, instead of signing that it was completed. Additionally, the U.S. FOIA (b) (6 explained the physician was to be notified and the resident's family was to be notified about NJ Ex Order NJ Exec Order The U.S. FOIA (b) stated she followed up with the nurses who signed that the daily NJ Ex Order was completed and had no NJ Ex Order results entered. The U.S. FOIA (b) continued that the nurses stated the resident had NJ Exec Order to NJ Ex Order 26.4(b)(1) and they did not document the NJ Exec Orde or notify the physician. On 8/7/25 at 11:04 AM, the surveyor interviewed the U.S. FOIA (b) (6) who stated daily NJ Ex Order 26 were ordered by the physician for residents who needed NJ Ex Order 26.4(b)(1) such as NJ Ex Or residents. The U.S. FOIA stated that the physicians were to be notified if resident NJ Exec Order 2 there was NJ Ex Order 26.4(b)(1) as per facility protocol. At that same time, the surveyor asked the U.S. FOIA where daily NJ Exec Order were documented, and the U.S. FOIA replied NJ Exec Order were documented in the NJ Ex Order 26 /vitals section of the EMR and there was a daily NJ Ex Order 26 order in the eMAR which the nurse would sign off. The U.S. FOIA further stated if a resident NJ Exec Order to be NJ Ex Order 26.4(upon the first NJ Exec Order the nurse was to notify the physician and the resident's representative to keep them up to date and involved in the plan of care. The U.S. FOIA explained if the resident continued to refuse it would be expected for staff to notify the physician every so often and document it in the EMR.	F0658		

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F0658 SS = D	Continued from page 26 Furthermore, the surveyor discussed the concern regarding Resident #77's daily [NJ Ex Order] documentation, [NJ Exec Orde] documentation and there being no documentation that the physician was made aware of the resident [NJ Exec Order 2] daily [NJ Ex Order 26.] The [U.S. FOIA] stated she was made aware of the issue by the [U.S. FOIA (b)], after surveyor inquiry. The [U.S. FOIA] acknowledged the concern and that it would be expected for nurses to document if a resident [NJ Exec Order] and to put in a [NJ Ex Order] result if the eMAR entry was signed as completed by nurse. On 8/7/25 at 1:41 PM, the surveyor notified the U.S. FOIA (b) (6) about the above concerns for Resident #77's daily [NJ Ex Order 26.] On 8/8/25 at 12:53 PM, the [U.S. FOIA (b)] the [U.S. FOIA] and the U.S. FOIA (b) (6) met with the survey team. The [U.S. FOIA] stated the staff were in-serviced about the expectation for daily [NJ Ex Order 26] including the importance of documenting [NJ Exec Order 2] notifying the physician and resident's representative. There was no additional information provided by the facility. A review of the facility's "Weight Assessment and Intervention Policy", last revised in March 2022, revealed under Policy Statement, Resident weights are monitored for undesirable or unintended weight loss or gain...Under Policy Interpretation and Implementation revealed:…2. Weights are recorded in each unit's weight record chart and in the individual's medical record… NJAC 8:39-27.1(a)	F0658		
F0677 SS = D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and review of facility provided documents, it was determined that the facility failed to provide appropriate NJ Ex Order 26.4(b)(1) care, for residents who were [NJ Ex Order 26.4(b)(] on staff [NJ Ex Order 26.4(b)(] for care, by failing to provide [NJ Ex Order 26.4(b)(1)] care. This deficient practice was identified for 1 of 2 residents	F0677	1. WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS AFFECTED BY THE DEFICIENT PRACTIC On 8/5/25, the US FOIA (b)(6)) and CNA #2 were immediately educated by the DON on how to perform [NJ Ex Order 26.4(b)(1)] care based on the facility's [NJ Exec Order 2] Care Competency. CNA #2 was educated by the DON on performing initial rounds at the start of the shift to identify which resident's require [NJ Ex Order 26.4(b)(1)] care and to perform periodic rounds on her assignment. A [NJ Exec Order 26.4b1] assessment was performed on Resident #14 on [NJ Exec Order 26.] by the DON. Resident #14 was found to be [NJ Ex Ord] and [NJ Ex] with no signs of [NJ Ex Order 26.4(b)(1)] or [NJ Ex Order 26.4(b)(1)] noted.	10/8/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315386	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLAS REHABILITATION AND HEALTHCARE AT MAYWOOD	100 WEST MAGNOLIA AVENUE , MAYWOOD, New Jersey, 07607

(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
F0677 SS = D	Continued from page 27 reviewed for NJ Ex Or care (Resident #14). This deficient practice was evidenced by the following: On 8/5/25 at 11:07 AM, the surveyor asked the U.S. FOIA (b) (6) [redacted]) to accompany the surveyor inside Resident #14's room. Both the surveyor and the U.S. FOIA (b) (6) observed the resident lying on bed with NJ Ex Order 26.4(b)(1) and clothing on top of the bed near resident's right side of the head. The resident was wearing a night gown and was covered by a blanket. The U.S. FOIA (b) (6) donned (put on) gloves and check the resident for NJ Ex Order 26.4(b)(1) both the surveyor and the U.S. FOIA (b) (6) observed the resident's NJ Ex Order 26.4(b)(1) was NJ Ex Order 2 and NJ Ex Order 26.4(b)(1), and there was NJ Ex Order 26.4(b)(1) [redacted]. The U.S. FOIA (b) (6) NJ Ex Order 26.4 the resident's NJ Ex Order 26.4(b)(1) [redacted] without NJ Ex Order or performing NJ Ex Order 26.4(b)(1) care. The U.S. FOIA (b) (6) went to the resident's toilet room and performed handwashing. At that same time, the surveyor asked the U.S. FOIA (b) (6) what time the resident should be done for NJ Ex Order checked or changed for NJ Ex Order 26.4(b)(1) care, and what was NJ Ex Order 26.4(b). The U.S. FOIA (b) (6) confirmed and stated, that was a NJ Ex Order 2 [redacted]", and the resident should have been changed. The U.S. FOIA (b) (6) also confirmed that the NJ Ex Order 26.4(b)(1) was NJ Ex Order 26.4(b)(1). On 8/5/25 at 11:30 AM, the surveyor interviewed Certified Nursing Aide #1 (CNA#1), who informed the surveyor that the CNA assigned to the resident was probably with other resident, and unavailable for an interview at that time. On 8/5/25 at 11:38 AM, the surveyor interviewed the assigned CNA of the resident, CNA#2, who informed the surveyor that she was unable to state how many residents she had today in her assignment because the U.S. FOIA (b) (6) took her paper that included her assignments. CNA#2 confirmed that Resident #14 was assigned to her. CNA#2 also stated that she came in today at 7:00 AM (7 AM) and she provided breakfast of Resident #14. She further stated that she was unable to check resident if the resident was NJ Ex and was unable to provide NJ Ex Order 26.4(b)(1) and morning care since 7 AM. On that same date and time, CNA#2 stated that she was unable to provide morning and NJ Ex Order 26.4(b)(1) care to Resident #14 at this time due to the U.S. FOIA (b) (6) took her	F0677	Continued from page 27 2. HOW WILL THE FACILITY IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THIS SAME DEFICIENT PRACTICE All residents coded as dependent for toileting have the potential to be affected by this deficient practice. 3. WHAT MEASURES WILL BE PUT IN PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT OCCUR On 8/5/2025, the DON or designee audited all active incontinent residents to ensure incontinence care was provided in a timely manner. The facility educator or designee in-serviced all licensed nurses and CNAs on the facility's Perianal Care Competency. The Unit Manager (UM)or designee will audit the incontinence care of 10 randomly selected dependent residents weekly x 1 month, then monthly x 3 months to ensure incontinence care is being rendered timely and correctly. 4. HOW WILL THE FACILY MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR The DON or designee will report the results of the audits to the monthly QAPI meeting x 4 months to ensure compliance and if further action is necessary.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315386	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLAS REHABILITATION AND HEALTHCARE AT MAYWOOD	100 WEST MAGNOLIA AVENUE , MAYWOOD, New Jersey, 07607

(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
F0677 SS = D	Continued from page 28 linen cart and she did not know as to why. CNA#2 confirmed that since 7 AM, this was the 1st time she would provide NJ Ex Order 26.4(b)(1) and morning care to the resident for 7:00 AM-3:00 PM shift. On 8/6/25 at 12:05 PM, the surveyor interviewed the U.S. FOIA (b) (6)), the assigned nurse of the resident, who stated that the resident was NJ Ex Order 26.4(b)(. The U.S. F further stated that the resident was compliant with care including NJ Ex Order 26.4(b)(1) care, and there were no reports from the aides that the resident had NJ Exec Order care. On 8/6/25 at 12:15 PM, the surveyor interviewed the U.S. FOIA (b) (6), and the surveyor notified the U.S. FOIA (b) (6) of the concern that the tasks tab of the CNA for NJ Ex Order 26 accountability from NJ Ex Order 26 to NJ Ex Order 26 there were days that only one entry and two entries versus three entries of documentation on other days. The U.S. FOIA (b) (6) stated that there should be three entries to show that NJ Ex Order 26.4(b)(1) was provided each shift by the CNAs. She acknowledged the printed NJ Ex Order 26 task had one entry on NJ Ex Order 26.4 two entries for NJ Ex Order 26.4 NJ Ex Order 26 NJ Ex Order 26 and NJ Ex Order 26 The U.S. FOIA (b) (6) had no answer as to why there were days with no three entries for NJ Ex Order 26.4(b)(1) to reflect that the NJ Ex Order 26.4(b)(1 care was provided by three shifts (7-3, 3-11, and 11-7 shifts). On 8/6/25 at 12:40 PM, the surveyor interviewed CNA#1 regarding the tasks tab for CNAs accountability log for NJ Ex Order CNA#1 informed the surveyor that as a CNA she document in the computer at the end of their shift or on times that they remember to document, including NJ Ex Order 26.4(b)(1) that was provided to the resident. She further stated that each shift, the expectation was for them to document the care provided in the tasks tab of computer. She also stated that there should be three entries in each category in the tasks of the CNAs. The surveyor reviewed the medical records of Resident #14. A review of the Admission Record (an admission summary) or face sheet, revealed, Resident #14 had been admitted with diagnoses which included but were not limited to; NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1)	F0677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315386	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLAS REHABILITATION AND HEALTHCARE AT MAYWOOD	100 WEST MAGNOLIA AVENUE , MAYWOOD, New Jersey, 07607

(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
F0677 SS = D	Continued from page 29 NJ Ex Order 26.4(b)(1), and NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), and NJ Ex Order 26 A review of the comprehensive Minimum Data Set (cMDS), an assessment tool used to facilitate care, with an assessment reference (ARD) date of NJ Ex Order 26., had a Brief Interview for Mental Status (BIMS) score of NJ out of 15 indicating NJ Ex Order 26.4(b)(1). The cMDS further documented that Resident #14 was always NJ Ex Order 26.4(b)(1) of NJ Ex Order 26.4(b)(1). A review of the electronic medical records, under tasks of the CNA, revealed, NJ Ex Order 26. hygiene (NJ Ex Order 26.4(b)(1) was coded for NJ Ex Order 26.4(b)(from NJ Ex Order 26. to NJ Ex Order. A review of the Annual Evaluation dated NJ Ex Order 26., that was electronically signed by the U.S. FOIA (b) (6) or NJ Ex Order 26.4 revealed that the resident was coded as NJ Ex Order 26.4(b)(for NJ Ex Order 26.4(b)(1). A review of the personalized care plan (CP) included a focus area, NJ Ex Order 26.4(b)(1) deficit related to NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(NJ Ex Order 26.4(b)(NJ Ex Order 26.4 , and NJ Ex Order 26.4(b)(1) that was created on NJ Ex Order 26., by the U.S. FOIA (b) (6), with an intervention that included but not limited to NJ Ex Order 26.4("I am NJ Ex Orde staff for NJ Ex Order 26.4(." On 8/7/25 at 1:35 PM, the survey team met with the U.S. FOIA (b) (6)) and the U.S. FOIA (b) (6)), and the surveyor notified them of the above observation and findings of Resident #14's NJ Ex Order 26.4(b)(1) care. A review of the provided NJ Ex Order 26.4(b)(1) list that was provided by the U.S. FOIA (revealed that Resident #14 was included in the list. A review of the facility's "Urinary Incontinence-Clinical Protocol Policy" that was provided by the U.S. FOIA (b) with a revision date of April 2018, did not include information about NJ Ex Order 26.	F0677		

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ATLAS REHABILITATION AND HEALTHCARE AT MAYWOOD	100 WEST MAGNOLIA AVENUE , MAYWOOD, New Jersey, 07607

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F0677 SS = D	Continued from page 30 process for NJ Ex Order 26.4(b)(1) residents and the CNA responsibilities with NJ Ex Order 26.4(b)(1) care. On 8/11/25 at 1:00 PM, the survey team met with the U.S. FOIA (b) (6) and U.S. FOIA U.S. FOIA (b) (6), and the U.S. FOIA (b) (6) for an exit conference. The U.S. FOIA (b) (6) and U.S. FOIA did not provide additional information. NJAC 8:39-11.2 (e), 27.1(a), 27.2 (d)(h)	F0677		
F0684 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: Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice, by failing to; a.) follow the physician's order, document, and notify the physician if medications were not administered for 1 of 26 residents (Resident #4) reviewed and b.) ensure accurate documentation of NJ Ex Order assessment and description of NJ Ex Order 26.4(b)(1) for 1 of 23 residents (Resident #8) reviewed, in accordance to facility's protocol and policies. This deficient practice was evidenced by the following: Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the state of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling and provision of care supportive to or restorative of life and well-being, and executing medical regimes as prescribed by a licensed or otherwise legally authorized physician or dentist."	F0684	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THE RESIDENTS AFFECTED BY THE DEFICIENT PRACTICE On 8/7/25, a risk management report was completed for medication doses not administered on NJ Ex Order 2 for Resident # 4. A NJ Ex Order 26.4(b)(1) assessment was performed on Resident #4, and NJ Ex Order 26.4(b)(1) were noted. The provider was notified of the missed doses and labs were ordered. On 8/8/25, LPN # 2 was immediately in-serviced by the facility's educator on the facility's Medication Administration Policy. On 8/7/25, the Infection Preventionist (IP) evaluated Resident # 8 NJ Ex Order 26 for any signs or symptoms of NJ Ex Order 26.4 The NJ Ex Order 26 did not display NJ Ex Order 26.4 , NJ Ex Order 26.4(b)(1, NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4 or NJ Ex Order 26.4 The IP changed the NJ Ex Order 26.4(b)(1) as per the facility's NJ Exec Orde Care Policy. On 8/7/25 LPN #3 was immediately in-serviced by the facility's educator on the facility's NJ Exec Orde Care Policy and Handwashing/Hand Hygiene Policy as well as sanitization of the NJ Exec Orde treatment cart, reusable supplies, and bedside tables. On 8/7/25, the treatment cart utilized by LPN #3, all reusable supplies including scissors, and resident #8's bedside table, were thoroughly disinfected with bleach wipes. HOW WILL THE FACILITY IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THIS SAME DEFICIENT PRACTICE All residents who require wound care have the potential to be affected by this deficient practice.	09/12/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315386	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/11/2025

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ATLAS REHABILITATION AND HEALTHCARE AT MAYWOOD	100 WEST MAGNOLIA AVENUE , MAYWOOD, New Jersey, 07607

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F0684 SS = D	Continued from page 31 Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." 1.On 8/5/25 at 10:58 AM, Surveyor #1 (S#1) interviewed the U.S. FOIA (b) (6)) in the 3rd floor nursing station, who informed S#1 that Resident #4 was a NJ Ex Order 2 resident. On 8/5/25 at 11:40 AM, S#1 asked Licensed Practical Nurse #1 (LPN#1) about the whereabouts of the resident, and she stated that the resident was NJ Ex Order 26.4(b). LPN#1 stated that the resident's NJ Ex Order 2 days were every Tuesday, Thursday, and Saturday. S#1 reviewed the medical records of Resident #4, and revealed the following: The Admission Record (AR, an admission summary) reflected that the resident was admitted to the facility with diagnoses that included but were not limited to; NJ Ex Order 26.4(b)(1) [redacted], NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4 [redacted] NJ Ex Order 26.4(b)(1), and NJ Ex Order 26.4(b)(1)). A review of the most recent quarterly Minimum Data Set (qMDS), an assessment tool, with an assessment reference date (ARD) of NJ Ex Order 26, under Section NJ NJ Exec Order 26.4b1 revealed a brief interview for mental status (BIMS) score of NJ E of 15, which reflected that the resident had NJ Ex Order 26.4(b)(1). A review of Resident #4's Order Summary Report (OSR) included the following physician orders (PO):	F0684	Continued from page 31 WHAT MEASURES WILL BE PUT IN PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT OCCUR On 8/19/25, facility's educator began to in-service and perform competencies on all active licensed nurses on the facility's Medication Administration Policy, Wound Care Policy, Handwashing/ Hand Hygiene Policy and Pressure Ulcer/Skin Breakdown Clinical Protocol Policy. On 8/19/25, the DON or designee audited all active residents for medications not administered in the month of August to ensure proper documentation and provider notification were performed. On 8/19/25, the DON or designee audited all active residents with wounds and all new admissions in August to ensure identification and accurate documentation of wound assessment. The DON or designee will perform a missed medication audit weekly x 4 weeks, then monthly x 3 months to ensure proper documentation and provider notification. The DON or designee will perform 5 random audits per week on proper sanitization of equipment used during wound care weekly x 4 weeks, then monthly x 3 months to ensure correct sanitizing wipes are being used. The IP or designee will perform 5 random handwashing/hand hygiene audits per week x 1 month, then monthly x 3 months HOW WILL THE FACILY MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR The DON or designee will report the results of the audits results at monthly QAPI meetings x 4 months to ensure compliance or if further actions are necessary.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315386	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/11/2025

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ATLAS REHABILITATION AND HEALTHCARE AT MAYWOOD	100 WEST MAGNOLIA AVENUE , MAYWOOD, New Jersey, 07607

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F0684 SS = D	Continued from page 32 -Ordered date NJ Ex Order 26.4(b)(1) [redacted] tablet (tab), give 1 tab by mouth one time a day (OD) for NJ Ex Order 26.4(b)(1) -Ordered date NJ Ex Order 26.4(b)(1) [redacted] tab, give 1 tab by mouth two times a day (2x/day) for NJ Ex Ord -Ordered date NJ Ex Order 26.4(b)(1) [redacted] give 1 tab by mouth OD for NJ Ex Order 26.4(b)(1) [redacted]), do not give if NJ Ex Order 26.4(b)(1) [redacted] -Ordered date NJ Ex Order 26.4(b)(1) tab, give 1 tab by mouth 2x/day for NJ Ex Order 26.4(b)(1) [redacted] -Ordered date NJ Ex Order 26.4(b)(1) tab, give 1 tab by mouth 2x/day for NJ Ex Order 26.4(b)(1) [redacted]). The above PO were transcribed to the NJ Ex Order 26.4(b)(1) electronic Medication Administration Record (eMAR) and revealed that on NJ Ex Order, the above medications (meds) were coded as N during the morning of day shift, which indicated that the meds were not administered because the resident was NJ Ex Order 26.4(b)(1) Further review of the medical records revealed that there was no documented evidence that the physician was notified of the meds that were not administered. A review of the most recent Progress Notes (PN) with an effective date of NJ Ex Order 26, that was electronically signed by the physician, revealed the following meds and corresponding diagnosis: -NJ Ex Order 26.4(b)(1) for NJ Ex Order 26.4(b)(1) [redacted]. -NJ Ex Order 26.4(b)(1) tab for NJ Ex Order 26.4(b)(1) [redacted]. -NJ Ex Order 26.4(b)(1) for NJ Ex Order 26.4(b)(1) [redacted]) with NJ Ex Order and history of NJ Ex Order 26.	F0684		

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F0684 SS = D	Continued from page 33 On 8/6/25 at 11:55 AM, S#1 observed the resident seated in a wheelchair with NJ Exec Order in the dining room of 3rd floor with NJ Ex Order 26.4(b)(1) . On 8/6/25 at 11:56 AM, S#1 interviewed the U.S. FOIA (b) (6)) regarding resident's meds. The U.S. F stated that if the resident's meds were not administered for any reason, the nurse should notify the U.S. FOIA (b) (6)) and the physician. He further stated that the information about missed meds and notification of the U.S. F and the physician should be documented in the PN, that included what was the plan or order of the physician for missed meds. On that same date and time, S#1 notified the U.S. F of the above findings and concerns about the NJ Ex Order 2 eMAR that meds were not administered and was coded NJ On 8/7/25 at 1:35 PM, the survey team met with the U.S. FOIA (b) (6)) and the U.S. FOIA (b) (6)). S#1 notified the concerns above for Resident #4. On 8/8/25 at 10:02 AM, S#1 asked LPN#2 for an interview while at the nursing station of 2nd floor and she stated that she was in the middle of discharging another resident at this time and was unavailable. LPN#2 was the nurse who did not administer the above meds on NJ Ex Order 2 On 8/8/25 at 12:53 PM, the survey team met with the U.S. FOIA (b U.S. FOIA (and U.S. FOIA (b) (6) The U.S. FOIA (b) (stated that the nurse who did not administer the above meds was provided education, did a late entry note, and the facility initiated a medication error incident report after surveyor's inquiry. She further stated that "we" did order a stat (immediate) NJ Ex Order 26.4(b)(1) request order last night to check the level. The U.S. FOIA (b) (informed S#1 that there was NJ Ex Order 26.4(b)(1) since NJ Ex Order 2 vital signs were monitored every shift, and there was NJ Ex Order 26.4(b)(1) On 8/11/25 at 1:00 PM, the survey team met with the U.S. FOIA (and U.S. FOIA (U.S. FOIA (b) (6) , and the U.S. FOIA (b) (for an exit conference. The U.S. FOIA (and U.S. FOIA did not	F0684		

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ATLAS REHABILITATION AND HEALTHCARE AT MAYWOOD	100 WEST MAGNOLIA AVENUE , MAYWOOD, New Jersey, 07607

(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
F0684 SS = D	Continued from page 34 provide additional information. 2. On 8/5/25 at 10:18 AM, Surveyor #2 (S#2) observed Resident #8 lying in their bed, NJ Ex O and NJ Ex Order 26 . The resident was wearing NJ Ex Order 26.4(b)(1) . Resident #8 stated they had NJ Ex Order 26.4(to their NJ Ex Order 2 and had NJ Ex Order 26.4(b)(1) . The resident confirmed they received NJ Ex Order treatment and their NJ Ex Order was NJ Ex Order 26. On 8/7/25 at 9:20 AM, S#2 reviewed the electronic medical record (EMR) of Resident #8. A review of the AR documented the resident had diagnoses that included but were not limited to; NJ Ex Order 26.4(b)(1)), NJ Ex Order 26.4(b)(1)), NJ Ex Order 26.4(b)(1)), NJ Ex Order 26.4(b)(1) , and NJ Ex Order 26.4(b)(1) A review of the qMDS, with an ARD of NJ Ex Order , reflected a BIMS score of NJ E out of 15, which indicated the resident was NJ Ex Order 26.4(b)(1) . In Section NJ Ex Order 26.) of the MDS, Resident #8 was coded as having NJ Ex Order 26.4(b)(1) , and NJ Ex O . A review of the PO dated NJ Ex Order 26.4 documented to apply NJ Ex Order 26.4(b)(1) one time a day for NJ Ex Order 26.4(b)(1) ; clean with NJ Ex Order 26.4(b)(1) , apply with NJ Ex Order 26.4(b)(1) . On 8/7/25 at 10:15 AM, S#2 observed LPN#3 complete a NJ Ex Order care treatment for Resident #8. LPN#3 disinfected the treatment cart for preparing her NJ Ex Order care supplies using wipes from the container labeled “hand sanitizing wipes”. When preparing the NJ Ex Order care supplies onto a drape on the treatment cart. LPN#3 stated she would clean the re-usable scissors for the NJ Ex Order treatment to place on the drape. LPN#3 disinfected the scissors using wipes from the container labeled “hand sanitizing wipes”. After preparing the supplies for the NJ Ex Order care treatment LPN#3 went to wash her hands at the resident’s bathroom sink. The surveyor observed LPN#3 turn on the water faucet, apply soap, then wet her hands with the running water. The LPN lathered her hands for 20 seconds outside the water prior to rinsing, dried her hands with a paper towel then used the same paper towel to turn off the faucet. After washing her hands, LPN#3 applied gloves and using the wipes from the container labeled “hand sanitizing wipes” disinfected the resident’s bedside table. The	F0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315386	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLAS REHABILITATION AND HEALTHCARE AT MAYWOOD	100 WEST MAGNOLIA AVENUE , MAYWOOD, New Jersey, 07607

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F0684 SS = D	Continued from page 35 LPN placed a drape on the bedside table place [NJ Ex Order] care supplies. On 8/7/25 at 10:35 AM, after completion of the [NJ Ex Order] treatment, LPN#3 went to wash her hands at the resident's bathroom sink. S#2 observed LPN#3 turn on the water faucet, apply soap, then wet her hands with the running water. The LPN lathered her hands for 20 seconds outside the water prior to rinsing, dried her hands with a paper towel then used the same paper towel to turn off the faucet. Outside of the resident's room, S#2 observed LPN#3 disinfect the scissors, and the top of the treatment cart using wipes from the container labeled "hand sanitizing wipes". On 8/7/25 10:45 AM, S#2 interviewed LPN#3 after completion of the [NJ Ex Order] care treatment about what to use when disinfecting equipment. LPN#3 showed the bleach wipes (blue top) found in the medication (med) cart and the hand sanitizing wipes (white top) on the top of the treatment cart could be used to disinfect equipment. S#2 discussed their observation of the use of hand sanitizing wipes to disinfect equipment and asked if it was part of the facility's protocol. LPN#3 stated that she believed it was ok to use to disinfect equipment. At that same time, S#2 asked LPN#3 about the steps in the hand hygiene process. LPN#3 stated she would open the faucet, apply soap, lather for at least 20 seconds, rinse her hands, dry hands with a paper towel and turn off faucet with the paper towel. S#2 asked if the same paper towel to dry hands would be used to turn off the faucet. LPN#3 stated the same paper towel could be used to turn off the faucet. S#2 discussed the observed concern with hand hygiene of applying soap first prior to wetting hands; and using the same paper towel instead of using another paper towel to turn off faucet. LPN#3 provided no additional verbal response. On 8/7/25 at 10:49 AM, S#2 interviewed a [U.S. FOIA (b) (6)] , about what could be used to disinfect equipment including treatment carts. The [U.S. FOIA (b) ( ] replied bleach wipes were available to be used to disinfect equipment and surfaces. S#2 asked the [U.S. FOIA (b) ( ] if it was okay to use hand sanitizing wipes to disinfect equipment and surfaces, and the [U.S. FOIA (b) ( ] stated she would like to verify before providing the surveyor with an answer.	F0684		

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F0684 SS = D	Continued from page 36 On that same date and time, S#2 asked the (b) (9) about the hand hygiene process. The U.S. FOIA (b) stated to turn on the faucet, wet hands, apply soap, lather hands for at least 15-20 seconds, rinse hands, dry with paper towel and take another paper towel to turn off faucet. S#2 discussed the concerns observed during NJ Exec Ord treatment. The U.S. FOIA (b) acknowledged the concerns and stated she will follow up with LPN#3 to provide in-service education. On 8/7/25 at 11:01 AM, S#2 interviewed the U.S. FOIA (b) (6)) about disinfecting equipment and surfaces. The U.S. stated bleach wipes were used in the facility. S#2 asked the U.S. if hand sanitizing wipes could be used, and the U.S. replied that the hand wipes were for hand use only. S#2 asked the U.S. about the hand hygiene process. The U.S. stated to turn on the faucet, wet hands, apply soap, lather hand for at least 20 seconds, dry hands with paper towel and grab another paper towel to turn off faucet. S#2 discussed the observed concerns during NJ Ex Order treatment. The U.S. acknowledged the concerns, and no further verbal response was provided. On 8/7/25 at 11:04 AM, S#2 interviewed the U.S. FOIA about what to use when disinfecting equipment and surfaces. The U.S. FOIA stated staff were to use bleach wipes. S#2 asked the U.S. FOIA if hand sanitizing wipes could be used. The U.S. FOIA replied those wipes were for hand use only. S#2 discussed the concern observed during the NJ Ex Order treatment, The U.S. FOIA acknowledged the concern and stated she would follow up. At that same time, S#2 asked the U.S. FOIA about the hand hygiene process. The U.S. FOIA stated the process was to turn on the faucet, wet hands, apply soap, lather hands for at least 20 seconds, dry hands with a paper towel and then grab another paper towel to turn off the faucet. S#2 discussed the observed concerns during wound treatment. The U.S. FOIA acknowledged the concerns, and stated she would follow up with the LPN. On 8/7/25 at 1:41 PM, S#2 notified the U.S. FOIA the U.S. FOIA of the concerns observed during the NJ Exec Ord treatment related to the use of hand sanitizing wipes used to disinfect equipment and surfaces and hand hygiene technique by the LPN#3. On 8/8/25 at 8:50 AM, S#2 conducted additional review	F0684		

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F0684 SS = D	Continued from page 37 of Resident #8's EMR which revealed the following: A care plan (CP) with a focus area, "I am at risk of NJ Ex Order 26.4(b)(1) r/t [related to] NJ Ex Order 26.4(b)(1)" had an initiated date of NJ Ex Order 26. Interventions included to assess for changed in NJ Ex Order 26.4(b)(1) each shift; NJ Ex Order 26.4(b)(1) as needed; keep NJ Ex Order 26.4(b)(1); NJ Ex Order 2 and NJ Ex Order 26.4(b)(1) A CP with a focus area, "I have an NJ Ex Order 26.4(b)(1) deficit r/t NJ Ex Order 26.4(b)(1), NJ Ex Order ," had an initiated date of NJ Ex Order 26. Interventions included but were not limited to monitor NJ Ex Order 26.4(b)(1) and observe for NJ Ex Order 26.4 NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b) NJ Ex Or NJ Ex Order 26 and report changes to nurse. A CP with a focus area, "I have NJ Ex Order 26.4(b)(1), NJ Ex Ord had an initiated date of NJ Ex Order 26 Interventions included but were not limited to monitor the extremities for signs and symptoms of NJ Ex Orde NJ Ex Order 26.4(or NJ Ex Order 2 A review of the U.S. FOIA (b) (6) note dated NJ Ex Order , by the U.S. FOIA (b) (6)) revealed the resident was being initially evaluated for a NJ Ex Order 26.4(b)(1), present upon admission. The NJ Ex O was evaluated and classified as NJ Ex Order 26.4(b) . The NJ Ex Order 26.4(b)(1) were NJ Ex Order 26.4(b)(1) A review of the IDCP meeting note dated NJ Ex Order 26, revealed the resident's NJ Ex Order 26.4(b)(1) was discussed with the resident's representative (RR). A review of the Readmission evaluation dated NJ Ex Order 26. revealed no documentation of NJ Ex Order 26.4(b)(1). A review of the PN and assessments for NJ Ex Order 26. to NJ Ex Order 2 revealed no additional documentation regarding the NJ Ex Order 26.4(b)(1) to indicate when the NJ Ex Order 2 was identified. Additional review of weekly NJ Ex Order 26.4(b)(1) completed by nurses after the U.S. FOIA (b) s evaluation of the NJ Ex Order 26.4(on NJ Ex Order , revealed no documentation of the presence of NJ Ex Order 26.4(b)(1) on NJ Ex Order 26 NJ Ex Order 26.4 NJ Ex Order 26 , NJ Ex Order 26 , and NJ Ex Order 26 . On 8/8/25 at 9:09 AM, S#2 interviewed the U.S. about NJ Ex O assessments and NJ Ex Order 2 evaluation by nursing staff. The U.S. stated that at times he would conduct rounds with	F0684		

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F0684 SS = D	Continued from page 38 the U.S. FO or with nurses to see residents' NJ Ex Order 26.4 The U.S. stated upon admission the nurse would complete a NJ Ex Order 26.4(b)(1) assessment. The admission assessment nurse would document any findings such as NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4 The U.S. continued to explain hospital records would be reviewed to determine if NJ Ex Order 26.4 identified was a pre-existing NJ Ex Order or a new one. Whether the NJ Ex Order was pre-existing or new, the U.S. stated the nurse would notify the physician for treatment orders; notify the U.S. FO and notify the U.S. FO to evaluate the resident. On 8/8/25 at 9:32 AM, S#2 interviewed the U.S. FOIA (over the phone. S#2 asked the U.S. FOIA (about Resident #8's NJ Ex O . The U.S. FOIA (b reviewed her documentation and notes for Resident #8. The U.S. FOIA (stated she evaluated Resident #8 for a NJ Ex Order 26.4(b)(1) on NJ Ex Order. The U.S. FOIA (further explained the NJ Ex Order was NJ Ex Order 2 in nature and recommended NJ Ex Order 26.4(b)(1) treatment which was effective, and the resident's NJ Ex Order 26.4(b)(1) on NJ Ex Order. S#2 asked about the U.S. FOIA ('s note dated NJ Ex Order, which indicated NJ Ex Order was present on admission. The U.S. FOIA (reviewed her notes, stated it was NJ Ex Order 26.4(b)(1) that she believed it was an NJ Ex Order 26.4(b)(1) prior to admission and had NJ Ex Order 26.4(b)(1). The U.S. FOIA (believed that's why she indicated present upon admission in her notes. The U.S. FOIA (stated the NJ Ex Order was NJ Ex Order 26.4(b) and NJ Ex Order 26.4(b)(1). The U.S. FOIA (further explained that she had been seeing Resident #8 prior for their NJ Ex Order 26.4(b)(1) and did not have NJ Ex Order 26.4(b)(1). On 8/8/25 at 11:26 AM, S#2 interviewed LPN#4 about NJ Ex O assessments for residents. LPN#4 stated nurses would complete NJ Ex O assessments upon resident admissions and document in their notes a detailed explanation of what was identified. LPN#4 stated there was a second day NJ Ex O assessment to complete a NJ Ex Order 26.4(b)(and then weekly NJ Ex Order 26.4(b)(1) were ordered to be continued. LPN#4 further explained it was expected for nursing staff if any NJ Ex Order 26.4(b)(1) noted during care to inform the nurse, and they will notify the physician. At that time, S#2 asked LPN#4 if a new NJ Exec Ord was identified by the nurse what is the protocol. LPN#4 stated the nurse would notify the physician, describe the NJ Ex Order 2 obtain treatment orders, and follow up with the U.S. FOIA (b) (6), who visited weekly. LPN#4 acknowledged all findings should be documented in the EMR. On 8/8/25 at 12:53 PM, the U.S. FOIA (b) the U.S. FOIA (and the U.S. FOIA (b) (6)) met with the survey team. The U.S. FOIA stated competency, and	F0684		

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F0684 SS = D	Continued from page 39 in-service education was completed with LPN#3. On 8/8/25 at 1:40 PM, S#2 notified the U.S. FOIA (b the U.S. FOIA and the U.S. FOIA (b) (of the concern there was no documentation by the nurses regarding Resident #8's NJ Ex Order 26.4(b)(1) as identified above. The U.S. FOIA stated she was working on the wound timeline and provide additional information to S#2. On 8/11/25 at 11:43 AM, the U.S. FOIA (b the U.S. FOIA and the U.S. FOIA (b) (met with survey team. The U.S. FOIA stated Resident #8 was re-admitted to the facility with no NJ Ex Order 26.4(and the NJ Ex Order 26.4(b)(1) was identified NJ Ex Orde on NJ Ex Order. The U.S. FOIA further explained an incident report was completed. S#2 asked if would be expected for the nurses to document their findings of a new wound in the EMR. The U.S. FOIA acknowledged that it would be expected for the nurses to document a note in the resident's EMR. There was no additional information provided by the facility. A review of the facility's "Wound Care Policy" with a last revised dated of October 2010, under Steps in the Procedure…21. Wipe reusable supplies with alcohol as indicated… The policy did not further address disinfecting of equipment and surfaces. A review of the facility's "Handwashing/Hand Hygiene Policy" with a last revised date of October 2023, under Washing Hands revealed:…1. Wet hands first with warm water, then apply an amount of product recommended by the manufacturer to hands…3. Rinse hands with water and dry thoroughly with a disposable towel…4. Use towel to turn off the faucet… A review of the facility's "Pressure Ulcers/Skin Breakdown- Clinical Protocol Policy" with a last revised date of April 2018. The policy did not address the protocol for new wound identified or the expectation for documentation by nurses regarding a wound. N.J.A.C. 8:39-3.2 (a), (b); 19.4; 27.1 (a)	F0684		
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.	F0686	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR RESIDENTS AFFECTED BY THE DEFICIENT PRACTICE Resident #113 was seen by the NJ Ex Order 2 Consultant on NJ Ex Order and NJ Ex Order 26.4 Consults revealed an overall NJ Ex Order 26.4(b)(1) with no NJ Ex Order 26.4(b)(1) identified. The DON verified NJ Ex Order treatment orders in	09/12/2025

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F0686 SS = D	Continued from page 40 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 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, and record review it was determined that the facility failed to provide care and services consistent with professional standards of practice for a resident with NJ Ex Order 26.4(b)(1). This deficient practice was identified in 1 of 2 residents (Resident #113), reviewed for NJ Ex Order 26.4(b)(1) care and prevention. The deficient practice was evidenced by the following: On 8/5/25 at 10:24 AM, the surveyor observed Resident #113 lying in the bed in their room. Resident #113 was NJ Ex Or and NJ Ex Order 26.4(b)(1). The resident had NJ E their care. On 8/8/25 at 8:50 AM, the surveyor reviewed the hybrid (paper and electronic) medical records of Resident #113. A review of the Admission Record (an admission summary) reflected that the resident had diagnoses that included but were not limited to; NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b NJ Ex Order 26.4(b)(1) , and NJ Ex Order 26.4(b)(1). A review of the comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of NJ Ex Order 2 with a Brief Interview Mental Status (BIMS) score of NJ E out of 15, which indicated the resident was NJ Ex Order 26.4(b)(1). Under Section NJ Ex Order 26.4(b)(1)), Resident #113 was coded for having NJ Ex Order 26.4(b)(1)) and NJ Ex Order 26.4(b)(1)	F0686	Continued from page 40 place. The Director of Nursing (DON), Assistant Director of Nursing (ADON) and Unit Managers (UMs) performed NJ Exec assessments on all active residents to ensure all NJ Exec Order 26.4b1 requiring NJ Exec Ord treatments were documented and have current treatment orders. No other residents were identified as being affected. This was completed on 8/19/2025. HOW WILL THE FACILITY IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THIS SAME DEFICIENT PRACTICE All residents with skin impairments, and all new admission residents have the potential to be affected by this deficient practice. WHAT MEASURES WILL BE PUT IN PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT OCCUR On 8/19/2025, the facility's educator or designee in-serviced all active licensed nurses on documenting skin impairments and obtaining physician orders for wound care upon admission or upon identification of the skin impairment. The DON or designee audited all new residents admitted to the facility in August to identify if skin impairments with wound care orders were present on admission. The DON or designee will audit all new admissions weekly x 4 weeks then monthly x 3 months to ensure any identified skin impairments have treatments and documentation completed timely in the electronic health record (EHR). HOW WILL THE FACILITY MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR The DON or designee will report the results of the audit at the monthly QAPI meetings x 4 months to ensure compliance or if further actions are necessary.	

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F0686 SS = D	Continued from page 41	F0686		

NJ Ex Order 26.4(b)(1) .

The resident had a care plan (CP) with a focus that read, “I have NJ Ex Order 26.4(b)(1) r/t [related to] … NJ Ex Order 26.4(b)(1) …” had an initiated date of NJ Ex Order 26 Interventions of the CP included, but were not limited to: Observe for signs and symptoms of NJ Ex Order 26.4(b)(1) and intervene accordingly; treatments as ordered; NJ Ex Order evaluation weekly to determine progress or NJ Ex Order 26.4(b)(1).

A U.S. FOIA (b) (6)) note, written by the NJ Exec Ord consultant physician U.S. FOIA (b) (dated NJ Ex Order 26, indicated the resident was evaluated for NJ Ex Order 26.4(b)(1). The U.S. FOIA (classified the NJ Ex Order as NJ Ex Order 26.4(b)(1) and recommended NJ Ex Order 26. to rule out NJ Ex Order 26.4(b)(1) as NJ Ex Order 26.4(b)(1). Additionally, the U.S. FOIA (b recommended NJ Ex Order 26.4(b)(1), and NJ Ex Order treatment orders to NJ Ex Order 26.4(b)(1) with NJ Ex Order 2 apply NJ Ex Order 26.4(b)(1) , and NJ Ex Orde and NJ Ex Order 26.4(b)(1).

An admission assessment dated NJ Ex Order 26, revealed there was no documentation of NJ Ex Order 26.4(b)(1).

An admission second day NJ Exec evaluation dated NJ Ex Order 26, revealed the resident had NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1). The NJ Ex Order 26.4(was indicated as NJ Ex Orde and had no description documented.

The NJ Ex Order 26.4(b)(electronic Treatment Administration Record (eTAR) revealed no treatment orders for the NJ Ex Order 26.4(b)(1).

A review of the physician’s orders (PO) revealed there was no NJ Ex Order treatment order for the NJ Ex Order 26.4(from NJ Ex Order 26 to NJ Ex Order.

A PO dated NJ Ex Order, indicated to NJ Ex Order 26 and NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(. Monitor for changes NJ Ex Order 26

A review of the NJ Ex Order 26.4(eTAR revealed for the NJ Ex Order

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ATLAS REHABILITATION AND HEALTHCARE AT MAYWOOD	100 WEST MAGNOLIA AVENUE , MAYWOOD, New Jersey, 07607

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F0686 SS = D	Continued from page 42 treatment order, the NJ Ex Order and NJ Ex Order 26.4 entry were left blank and unsigned. A review of progress notes (PN) revealed there was no documentation by nurses to indicate treatment for Resident #113's NJ Ex Order 26.4(b)(1), follow up with the physician between NJ Ex Order 26 to NJ Ex Order. A NJ Ex Order 26.4 PN dated NJ Ex Order, did not indicate any recommendation for NJ Ex Order 26.4(b)(1) treatment orders. There was no documentation found to indicate that the resident was seen NJ Exec Order 26.4 by NJ Ex Order 26.4 or NJ Ex Order 26.4 consultant. On 8/8/25 at 9:09 AM, the surveyor interviewed the U.S. FOIA (b) (6)) who created the second day NJ Ex O assessment. The U.S. confirmed that was his username. The U.S. stated that at times he would conduct rounds with the U.S. FO or with nurses to see residents' NJ Ex Order 26.4 The U.S. stated upon admission the nurse would complete a NJ Ex Order 26.4(b)(1) assessment. The admission assessment nurse would document any findings such as NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4 The U.S. continued to explain hospital records would be reviewed to determine if a NJ Ex Order 2 identified was NJ Ex Order 26.4(b)(1) or a NJ Ex Order 26.4. Whether the NJ Ex Order was NJ Ex Order 26.4(b)(1), the U.S. stated the nurse would notify the physician for treatment orders; notify the resident's representative; and notify the U.S. FO to evaluate the resident. The surveyor asked the U.S. if he recalled Resident #113. The U.S. replied the resident was not familiar to him. The surveyor reviewed with the U.S. the NJ Ex Order 26.4(b)(1) assessment in the EMR (electronic medical record). The U.S. confirmed it was his documentation. The U.S. stated he does recall Resident #113 but could not remember anything from the time about the resident's NJ Ex Order 26.4(b) On 8/8/25 at 9:32 AM, the surveyor interviewed the U.S. FOIA (about Resident #113. The U.S. FOIA (stated her first evaluation of the resident was on NJ Ex Order 26., for the NJ Ex Order 26.4(b)(1) and that it had been NJ Ex Order 26 upon admission. The U.S. FOIA (further explained that she worried about NJ Ex Order 26.4(b)(1) due to NJ Ex Order 26.4(b)(1) and it had been ruled out by NJ Ex Or The surveyor asked U.S. FOIA (b) if she had seen the resident prior to NJ Ex Order 26. The U.S. FOIA (	F0686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315386	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLAS REHABILITATION AND HEALTHCARE AT MAYWOOD	100 WEST MAGNOLIA AVENUE , MAYWOOD, New Jersey, 07607

(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
F0686 SS = D	Continued from page 43 replied she did not and stated that she believed the staff were following up to determine if the resident could be seen by a [NJ Ex Order] consultant since they previously had [NJ Ex Order 26] and [NJ Ex Order 26.] on the case. The [U.S. FOIA (] could not speak to the treatment orders for Resident #113 prior to [NJ Ex Order 26.]. On 8/8/25 at 11:15 AM, the surveyor interviewed the [U.S. FOIA (b) (6)] over the phone who visited the resident on [NJ Ex Order]. The [U.S. FOIA (b) (6)] confirmed he had assessed and visited Resident #113 on [NJ Exec Orde]. The [U.S. FOIA (b) (6)] stated the resident had [NJ Ex Order 26] and NJ Ex Order 26.4(b)(1). The [U.S. FOIA (b) (6)] stated the resident had the NJ Ex Order 26.4(b)(1) prior to admission and he recommended for [NJ Ex Order 26.4(b)(]. The surveyor asked if the [U.S. FOIA (b) (6)] took care of the resident prior to [NJ Ex Order]. The [U.S. FOIA (b) (6)] stated the resident was new to him and he did not know the resident prior. The surveyor asked the [U.S. FOIA (b) (6)] about the [NJ Ex Order 2] treatment at the time of the visit and previously from the resident's admission. The [U.S. FOIA (b) (6)] stated the [NJ Ex Order] care team was always following the resident and he could not speak to the resident's previous treatment orders. The surveyor asked the [U.S. FOIA (b) (6)] if he made any treatment recommendations for the NJ Ex Order 26.4(b)(1) The [U.S. FOIA (b) (6)] replied he did not and recommended for staff to continue with the [NJ Ex Order] care team's recommendations. The [U.S. FOIA (b) (6)] added the [NJ Ex Order] care team were the primary on the case and on [NJ Ex Order 2] was the only time he saw the resident. On 8/8/25 at 1:40 PM, the surveyor notified the U.S. FOIA (b) (6)), the U.S. FOIA (b) (6)), and the U.S. FOIA (b) (6) of the concern of there being no documentation of [NJ Ex Order] treatment to Resident #113's [NJ Ex Order 26.4(], which was present on admission from [NJ Ex Order 26] to [NJ Ex Order]. There was no verbal response from the [U.S. FOIA (b)] [U.S. FOIA (] and the [U.S. FOIA (b) (] at this time. On 8/11/25 at 9:32 AM, the [U.S. FOIA] informed surveyor after interviewing staff that upon admission the [NJ Ex Order 26.4(was assessed by the nurse supervisor and the admitting nurse. The [U.S. FOIA] stated they applied [NJ Ex Ord] to the [NJ Ex Order] and did not document it. The [U.S. FOIA] further stated that the hospital record did not indicate [NJ Ex Order] treatment orders. The surveyor asked the [U.S. FOIA] if anyone followed up with the physician for treatment orders. The [U.S. FOIA] replied that a [U.S. FOIA (b)] order was entered and no treatment order was obtained. The [U.S. FOIA] could speak to why no treatment order	F0686		

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ATLAS REHABILITATION AND HEALTHCARE AT MAYWOOD	100 WEST MAGNOLIA AVENUE , MAYWOOD, New Jersey, 07607

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F0686 SS = D	Continued from page 44 was obtained for the [NJ Ex Order 26.4(b)(1)] assessed upon admission. The surveyor asked the [U.S. FOIA] who entered the PO on [NJ Ex Order], and the [(b) (9)] replied the [U.S.] did. The surveyor asked if anyone followed up with the [U.S. FOIA (b)] prior to their [NJ Ex Order 26] as the order was placed on [NJ Ex Order 26], and the [U.S. FOIA] replied no one followed up. On 8/11/25 at 11:43 AM, the [U.S. FOIA (b)] the [U.S. FOIA] and the [U.S. FOIA (b) (6)] met with the survey team. There was no additional information provided to the surveyor regarding Resident #113. A review of the facility's "Pressure Ulcers/Skin Breakdown-Clinical Protocol Policy", with a revised date of April 2018, under Assessment and Recognition revealed,… 1. The nursing staff and practitioner will assess and document an individual's significant risk factors for developing pressure ulcers; for example, immobility, recent weight loss, and a history of pressure ulcer(s)… 2. In addition, the nurse shall describe and document/report the following: a. Full assessment of pressure sore including location, stage, length, width and depth, presence of exudates or necrotic tissue… d. Current treatments, including support surfaces… 3. The staff and practitioner will examine the skin of newly admitted residents for evidence of existing pressure ulcers or other skin conditions…" The policy did not further address nursing assessment, documentation of resident wounds and care planning. NJAC 8:39-27.1 (a)(e)	F0686		
F0698 SS = D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is NOT MET as evidenced by:	F0698	1. WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS AFFECTED BY THE DEFICIENT PRACTICE The DON performed a [NJ Ex Order 26.4(b)(1)] assessment on Resident #4 on 8/5/25 and was determined to have [NJ Ex Order 26.4(b)(1)]. Late entry nurses' notes were entered on 8/2/25 and 8/5/25. The provider was notified of the blank section of the Hemodialysis Communication form on 7/10/25, 7/12/25, 7/22/25, 7/24/25, 8/2/25, and 8/5/25. 2. HOW WILL THE FACILITY IDENTIFY OTHER RESIDENTS	10/8/2025

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F0698 SS = D	Continued from page 45 Based on observation, interview, record review, and review of other pertinent documents, it was determined that the facility failed to ensure that staff provided adequate NJ Ex Order 26.4(b)(1) for a resident after returning from receiving offsite NJ Ex Order 26.4(b)(1) and provided care and services in accordance with professional standards clinical practice for 1 of 2 residents (Resident #4), reviewed for NJ Ex Order 26 services. The deficient practice was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." On 8/5/25 at 10:58 AM, the surveyor interviewed the U.S. FOIA (b) (6)) in the 3rd floor nursing station, who informed the surveyor that Resident #4 was NJ Ex Order 26.4(resident. On 8/5/25 at 11:40 AM, the surveyor asked the U.S. FOIA (b) (6) about the whereabouts of the resident, and she stated that the resident was in therapy. The U.S. FOI stated that the resident's NJ Ex Order 26 days were every Tuesday, Thursday, and Saturday. The surveyor asked for the resident's NJ Ex Order 26 communication records, and she stated that she would get back to the surveyor.	F0698	Continued from page 45 HAVING THE POTENTIAL TO BE AFFECTED BY THIS SAME DEFICIENT PRACTICE All residents receiving hemodialysis treatments have the potential to be affected by this deficient practice. 3. WHAT MEASURES WILL BE PUT IN PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT OCCUR The facility's educator or designee in-serviced all active licensed nurses on the facility's Hemodialysis Policy. The DON or designee audited all residents receiving hemodialysis treatment to ensure the communication form in the month of August were completed. The UMs or designee will audit each dialysis resident's hemodialysis communication forms 3 times a week x 4 weeks then monthly x 3 months to ensure completion. 4. HOW WILL THE FACILY MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR The DON or designee will report results of the audit at monthly QAPI meetings x 4 months to ensure compliance or if further action is necessary.	

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ATLAS REHABILITATION AND HEALTHCARE AT MAYWOOD	100 WEST MAGNOLIA AVENUE , MAYWOOD, New Jersey, 07607

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F0698 SS = D	Continued from page 46 On 8/5/25 at 11:50 AM, the NJ Ex Order 26.4(b)(1)) provided the resident's NJ Ex Order 26 binder. The surveyor reviewed the binder and the following dates from the NJ Ex Order 26 Communication Record (NJ Ex Orde were missing documentation from the NJ Ex Order 26.4(b)(1)) center nurse, and the bottom part of the form was blank with no information from the facility's receiving nurse after NJ Ex for dates NJ Ex Order , NJ Ex Order , NJ Ex Order 26 , NJ Ex Order 26 , NJ Ex Order 26. and NJ Ex Order 26.4 The surveyor reviewed the medical records of Resident #4, and revealed the following: The Admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses that included but were not limited to; NJ Ex Order [redacted], NJ Ex Order 26.4(b)(1) [redacted], NJ Ex Order 26.4(b)(1) [redacted], NJ Ex Order 26.4(b)(1), and NJ Ex Order 26.4(b)(1) [redacted] A review of the most recent quarterly Minimum Data Set (qMDS), an assessment tool, with an assessment reference date (ARD) of NJ Ex Order 26, under Section NJ [redacted] revealed a brief interview for mental status (BIMS) score of NJ E of 15, which reflected that the resident had NJ Ex Order 26.4(b)(1). The qMDS reflected that the resident was NJ Ex Order 2 A review of Resident #4's Order Summary Report (OSR) included a physician orders (PO) with an ordered date o NJ Ex Order 2 for NJ Ex on Tuesday, Thursday, and Saturday with NJ Ex Ord time of 5:00 AM and pick up time of 4:15 AM. On 8/5/25 at 11:53 AM, the surveyor notified the U.S. FOIA (b) (6) of the above concerns with missing information from the NJ Ex nurse and blanks documentation from the facility receiving nurse in the NJ Ex Orde The U.S. FOIA (b) (6) stated that the top and bottom parts of the NJ Ex Or should be filled out by the facility nurse and the middle part for the NJ Ex Order 26 center, if the middle part was blank, the nurse from facility should call the NJ Ex Order 26 center.	F0698		

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F0698 SS = D	Continued from page 47 On 8/6/25 at 11:55 AM, the surveyor observed the resident seated in a wheelchair with cushion, in the dining room of 3rd floor with NJ Ex Order 26.4(b)(1) [redacted] On 8/6/25 at 11:56 AM, the surveyor interviewed the U.S. F[redacted] regarding the NJ Ex Or[redacted] of the resident. The surveyor also notified the U.S. F[redacted] of the above concerns with missing/incomplete documentation in NJ Ex Orde[redacted] The U.S. F[redacted] stated that he was unaware prior to surveyor's inquiry that the NJ Ex Or[redacted] had to be filled out completely. He further stated that at times no one notified him that the resident had returned from the NJ Ex[redacted] and that was why there were missing documentation from the communication records on the days he worked. On 8/7/25 at 1:35 PM, the survey team met with the U.S. FOIA (b) (6) [redacted]) and the U.S. FOIA (b) (6) [redacted]). The surveyor notified the U.S. FOIA ([redacted] and the U.S. FOIA[redacted] of the concerns above for Resident #4's NJ Ex Orde[redacted] On 8/8/25 at 12:53 PM, the survey team met with the U.S. FOIA (b)[redacted] U.S. FOIA ([redacted] and U.S. FOIA (b) (6) [redacted]. The U.S. FOIA (b) ([redacted] stated that the facility spoke to the nurses who did not fill out the NJ Ex Orde[redacted] two of the nurses said that they did assess the resident upon return to the facility from NJ Ex[redacted] but did not fill up the form. The U.S. FOIA (b) ([redacted] further stated that a late entry notes were entered after surveyor's inquiry. A review of the facility's "Hemodialysis Policy" that was provided by the U.S. FOIA (b)[redacted] with a reviewed/revised date of 12/2/24, revealed a policy that the facility will provide the necessary care and treatment, consistent with professional standards of practice, physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences, to meet the special medical, nursing, mental, and psychosocial needs of residents receiving HD. The purpose…the ongoing assessment of the resident's condition and monitoring for complications before and after dialysis treatments received at a certified dialysis facility…ongoing assessment and oversight of the resident before, during, and after dialysis treatments, including monitoring of the resident's condition during treatments, monitoring for complications, implementation of appropriate interventions, and using appropriate infection control practices; and ongoing communication and collaboration with the dialysis	F0698		

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F0698 SS = D	Continued from page 48 facility regarding dialysis care and services…#8. The nurse will monitor and document the status of the resident's access site(s) upon return from the dialysis treatment to observe for bleeding or other complications… On 8/11/25 at 1:00 PM, the survey team met with the U.S. FOIA (and U.S. FOIA U.S. FOIA (b) (6), and the U.S. FOIA (b) (for an exit conference. The U.S. FOIA (and U.S. FOIA did not provide additional information. NJAC: 8:39-11.2(b), 27.1(a)	F0698		
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 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.	F0756	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THE RESIDENTS AFFECTED BY THE DEFICIENT PRACTICE Resident # 134 was assessed by the NJ Ex Order 26.4(b)(provider on NJ Exec Orc and reviewed the admission drug regimen review. The LPN/UM completed the admission drug regimen review for Resident # 134 on NJ Exec Order Parameters were added to NJ Ex Order 26.4(b)(Resident # 134 had NJ Ex Order 26.4(b)(1 to receiving NJ Ex Order 26.4(b)(on NJ Ex Order 2 at 9 AM and not receiving NJ Ex Order 26.4(b)(and NJ Ex Order 26. on NJ Ex Order at 9 PM and NJ Ex Order 2 at 9 PM. outside of the prescribed parameters on NJ Ex Order 2 at 9 AM and should have been held on NJ Ex Order at 9 PM and NJ Ex Order 2 at 9 PM. The nurse was educated on 8/19/2025. HOW WILL THE FACILITY IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THIS SAME DEFICIENT PRACTICE All new admissions have the potential to be affected by this deficient practice. All residents with medications which have parameters have the potential to be affected. WHAT MEASURES WILL BE PUT IN PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT OCCUR On 8/19/25, the DON or designee audited all medications with parameters to ensure that parameters were followed as ordered. On 8/19/25, the DON or designee audited all midodrine orders to ensure parameters were in place. The facility educator or designee in-serviced all	09/12/2025

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F0756 SS = D	Continued from page 49 §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 interviews, record review, and a review of pertinent facility documents, it was determined that the facility failed to act on the U.S. FOIA (b) (6) Medication Regimen Review (MRR) in a timely manner for 1 of 23 residents, (Resident #134), reviewed. This deficient practice was evidenced by the following: The surveyor reviewed the hybrid medical record (electronic and paper) for resident #134, and revealed the following: A review of the Admission Record (an admission summary) reflected that the resident was admitted to the facility on with diagnoses of, but not limited to, NJ Ex Order 26.4(b)(1)) and NJ Ex Order 26.4(b)(1)). A review of the Social Services Assessment (SSA) dated NJ Ex Order , reflected that the resident had a Brief Interview for Mental Status (BIMS), a tool used to screen and identify NJ Exec Order 26.4b1 , score of NJ E out of 15, which indicated that Resident #134 was NJ Ex Order 26.4(b)(1) A review of the resident's electronic Medication Administration Record (eMAR) for NJ Ex Order 26.4(b)(1) , up to and including NJ Ex Order 2 revealed the following: -A physician order (PO) for NJ Ex Order 26.4(b)(1) give 1 tablet (tab) by mouth every 8 hours for NJ Ex Order 26.4(b)(1)). The above PO for NJ Ex Order 26.4(b) did not reflect any additional instructions to take or monitor NJ Ex Ord) or to not give the medication (med) if the NJ Ex was NJ Ex Order 26.4(b)(1) a certain level, also known as a parameter. The order was plotted to be given at	F0756	Continued from page 49 licensed nurses and primary care providers on the facility's Medication Regimen Review Policy as well as following parameters on medications that have parameters. The DON or designee audited all the admission drug regimen reviews in August to ensure timely review and completion. The DON or designee will audit all new admission drug regimen reviews weekly x 4 weeks then monthly x 3 months to ensure timely review and completion. The DON or designee will audit medications with parameters to ensure the parameters are followed. This will be done weekly x 4 weeks then monthly x 3 months. HOW WILL THE FACILY MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR The DON or designee will report the results of the audit results at the monthly QAPI meetings x 4 months to ensure compliance or if further actions are necessary.	

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ATLAS REHABILITATION AND HEALTHCARE AT MAYWOOD	100 WEST MAGNOLIA AVENUE , MAYWOOD, New Jersey, 07607

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F0756 SS = D	Continued from page 50 7:00 AM (7 AM), 3:00 PM (3 PM), and 11:00 PM (11 PM). -A PO for NJ Ex Order 26.4(b)(1)) oral tab NJ Ex Order 26.4 give 1 tab two times a day (2x/day) for NJ Ex Order 26.4(b)(1) hold for NJ Ex Order 26.4(b)(1) or NJ Ex The above PO order for NJ Ex Order 26.4(b)(was plotted to be given at 9:00 AM (9 AM) and 9:00 PM (9 PM). -A PO for NJ Ex Order 26.4(b)(1)) oral Tab NJ Ex Order 2 give 1 tab by mouth one time a day (OD) for NJ Ex Or hold for NJ Ex Order 26.4(b)(1) . The eMAR also revealed entries for NJ Ex Orde on NJ Ex Order at 9 AM that was not given when the NJ Ex was NJ Ex O and should have been, was given on NJ Ex Order 2 at 9 PM when the NJ Ex was NJ E and should have been held, and not given on NJ Ex Order at 9 PM when the NJ Ex was NJ Ex O and should have been given. The eMAR also revealed an entry for NJ Ex Order 26.4 on NJ Ex Order at 9 AM that was not given when the NJ Ex was NJ Ex O and should have been. A review of the resident's progress notes (PN), up to and including NJ Ex Order 26 documentation including but not limited to physicians, and other professional staff. The PN did not reveal any documentation referencing a NJ Ex Orde in person or remotely, by a NJ Ex Order 26.4(b)(1) nor any irregularities in medications (meds) or med changes. Further review of the PN, revealed a nursing note dated NJ Ex Order 2 that reflected on NJ Ex Order at 7:23 PM, a nurses notes that the resident was seen by the U.S. FOIA (b) (6) "today", with new recommendations for NJ Ex Order 26.4(b)(1)), to change NJ Ex Order 26.4(b)(1) 2x/day to NJ Ex Order 26.4(b)(1) 2x/day, d/c (discontinue) NJ Ex Order 26.4 and that the physician was made aware and was in agreement… The surveyor reviewed the electronic MRR (eMRR) for Resident #134, dated NJ Ex Order 26 that was provided by the U.S. FOIA (b) (6)) of the unit where Resident #134 resided. The U.S. FO stated that the eMRRs were kept in a binder in their office. The eMRR revealed several recommendations for nursing and at least one for the attending physician. The recommendations listed for nursing to address were as follows: 4. NJ Ex Order 26.4(b)(1) was recommended to be scheduled	F0756		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315386	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLAS REHABILITATION AND HEALTHCARE AT MAYWOOD	100 WEST MAGNOLIA AVENUE , MAYWOOD, New Jersey, 07607

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F0756 SS = D	Continued from page 51 and given with or immediately following a meal. Please review current administration times. 5. Med error(s) noted. NJ Ex Order 26.4(b)(1) was not always held as required by the physicians hold order NJ Ex Order 26.4(b)(1)). Please review 9 PM administration on NJ Ex Order 26.4. 6. Do not administer NJ Ex Order 26.4(b) after the evening meal or within four hours of bedtime to reduce the potential for NJ Ex Order 26.4(b)(1) during sleep. (a type of NJ Ex Order 26.4 that occurs specifically when a person is lying down). Further review of the resident's paper chart revealed that the facility's CP reviewed the resident's record in person on NJ Ex Order 26 and documented that an eMRR was done on NJ Ex Order . The recommendation listed for the attending physician to address was to review the concurrent use of NJ Ex Order 26.4 and NJ Ex Order 26.4(b)(1) for NJ Ex Or with NJ Ex Order 26.4(b) for NJ Ex Order 26.4(b)(1) due to opposing effects. "Please" clarify NJ Ex Order 26.4 and NJ Ex Order 26.4(b)(1) indications and continued use of all three meds. On 8/7/25 at 12:30 PM, the surveyor interviewed the CP, who stated if the eMRR had not yet been completed, they will do a complete review. If the eMRR had been done completely, the record will be considered as reviewed for the month. On 8/8/25 at 9:52 AM, the surveyor interviewed the U.S. FO for Resident #134. The surveyor asked the U.S. FO how the eMRR recommendations were addressed. The U.S. FO stated that she did them as soon as she could get to them. The U.S. FO stated that on admission, the request for an eMRR was sent to the wrong company, so it came back late. The surveyor asked the U.S. FO if it was common for midodrine to have a hold parameter. The U.S. FO stated yes, they usually do, but did not know why the order for Resident #134 did not have one. The U.S. FO also stated that the resident was seen the NJ Ex Order 26.4(b)(1)) by the U.S. FOIA (b) (6) who made med changes, but no parameter to NJ Ex Order 26.4(b)(1 The surveyor later reviewed the resident's PN which revealed a note by the U.S. FOIA (b) (6) dated NJ Ex Order 2 at 3:28 PM, after surveyor inquiry, that addresses the resident's meds in question. On 8/8/25 at 12:53 PM, the survey team met with U.S. FOIA (b) (6)),	F0756		

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F0756 SS = D	Continued from page 52 U.S. FOIA (b) (6)), and the U.S. FOIA (b) (6)). The surveyor asked what the expectation or procedure for how admission/eMRR reviews were handled, including but not limited to what were the expected outgoing/incoming time frames, were they kept in the medical record, how were they addressed. The U.S. FOIA stated that they were send out to the U.S. F office, then sent back, usually all within 24-72 hours of admission. They were kept in a binder on the floor and the nurse should follow up as soon as possible. The surveyor asked if four days to get the review and an additional three more days to act on, a total of seven days from admission would be an acceptable expectation. The U.S. FOIA stated no it should be quicker. At that same time, the surveyor also asked if there was an expectation for the nursing staff to follow the med parameters as the physician ordered them, and the U.S. FOIA stated yes, they should follow the order and document any other holds outside of that order. The U.S. FOIA ((and U.S. FOIA did not provide any further pertinent information. A review of the facility's "Medication Regimen Reviews Policy" that was provided by the U.S. FOIA with a revision date of February 2025, revealed under policy statement that a licensed pharmacist reviews the med regimen of each resident at least monthly. Under policy interpretation and implementation...#5. The MRR is conducted in collaboration with the resident, family members, and the interdisciplinary team (IDT)...Timeframe for reporting...#3. Copies of MRR, including physician responses, are maintained as part of the permanent medical record... NJAC 8:39-29.3(a)(1)	F0756		
F0759 SS = D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, it	F0759	1. WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS AFFECTED BY THE DEFICIENT PRACTICE The DON immediately assessed Residents #73 and #81 on 8/7/25 and NJ Ex Order 26.4(b)(1) were identified. The provider was notified of the medication error and did not place any new orders. Risk management reports were completed. The facility educator immediately in-serviced the U.S. F on 8/7/25 on the facility's Medication Administration Policy.	09/08/2025

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F0759 SS = D	Continued from page 53 was determined that the facility failed to ensure that all medications were administered without error of 5% or more during medication administration, two (2) nurses administered medications to four (4) residents. There were thirty (30) opportunities for error, three (3) errors were observed which calculated to a medication administration error rate of 10%. This deficient practice was identified for 2 of 4 residents, (Resident #73, Resident #81), that was administered medications by (one) 1 of two (2) nurses that were observed. The deficient practice was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case-finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling, and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." On 8/07/25 at 8:23 AM, the surveyor observed the U.S. FOIA (b) (6) prepare meds for Resident #81. The meds included an active physician's order (PO) for NJ Ex Order 26.4(b)(1) , give 1 tab by mouth two times a day (2x/day) for NJ Ex Order 26.4(b)(1) and NJ Ex Order 2 The surveyor observed the U.S. F prepare and administer Resident #81's medications (meds) which included one NJ Ex Order 26.4(b)(1)) tab. The surveyor then observed the U.S. F administer the NJ Ex Or along with other due meds to the resident. Upon return to the medication cart	F0759	Continued from page 53 2. HOW WILL THE FACILITY IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THIS SAME DEFICIENT PRACTICE All residents receiving multivitamin with minerals, docusate sodium capsules, and oral diabetic medications with recommended timing instructions have the potential to be affected by this deficient practice. 3. WHAT MEASURES WILL BE PUT IN PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT OCCUR The facility's educator or designee in-serviced all licensed nurses on the facility's Medication Administration Policy. The UM audited all the medication carts to ensure the availability of multivitamin with minerals and docusate sodium capsules. The DON or designee will audit the medication administration of 5 random residents weekly x 4 weeks then monthly x 3 months to ensure the correct type of medication was administered and oral diabetic medication was administered at the correct time. 4. HOW WILL THE FACILY MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR The DON or designee will report the results of the audit to the monthly QAPI meetings x 4 months to ensure compliance or if further actions are necessary.	

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F0759 SS = D	Continued from page 54 (med-cart), the surveyor asked the U.S. F to identify the bottle she took the NJ Ex O from. The U.S. F showed the surveyor the bottle labeled NJ Ex O tablets (tabs). The surveyor asked the U.S. F to compare the bottle label to the order on the resident's electronic medication administration record (eMAR). The U.S. F stated that it should have been with NJ Ex Order 26.4(On the same date, at 8:51 AM, the surveyor observed the same U.S. F prepare to administer meds to Resident #73. The meds included active POs for the following: NJ Ex Order 26.4(b)(1)), give 1 cap by mouth 2x/day for NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1), give 1 tab by mouth in the morning for NJ Ex Order 26.4(give 30 minutes (mins) before meals. The surveyor observed the U.S. F enter the resident's room and observe that the resident needed to be NJ Ex Order 26.4(b)(1) before med administration. The U.S. F then went to get assistance. The U.S. F returned with a staff member to aid in NJ Ex Order 26.4(b)(1) the resident a few minutes later. The surveyor observed that the resident had their morning meal tray on the over bed table. The surveyor observed the U.S. F prepare the resident's meds. The surveyor observed the U.S. F select and pour a med labeled NJ Ex Order 26.4(b)(1) tab along with the resident's other due meds. The surveyor accompanied the U.S. F to the resident's bedside for med administration. The surveyor observed the resident eating their morning meal. The nurse then administered the meds, including the NJ Ex Order 26(and NJ Ex Order 26.4(b)(1) Upon return to the med-cart, the surveyor asked the U.S. F to identify the bottle she took the NJ Ex Order 26.4(from. The U.S. F showed the surveyor the bottle labeled NJ Ex Order 26.4(tabs. The surveyor asked the U.S. F to compare the bottle label to the order on the resident's eMAR. The U.S. F stated that it should have been the NJ Ex Order 26.4(cap. The surveyor asked the U.S. F about the timing of the NJ Ex Order 26(and the directions how to give regarding meals. The U.S. F stated that it should be before meals, but she was a little late and the resident likes to eat now. The surveyor asked the U.S. F if a NJ Ex Order 26 med was late, what was the usual procedure. The U.S. F stated to document it late. The surveyor concluded the med pass observation with the U.S. FC	F0759		

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F0759 SS = D	Continued from page 55 On 8/7/25 at 1:36 PM, the survey team met with the U.S. FOIA (b) (6)) and U.S. FOIA (b) (6) to discuss the above concerns. The surveyor discussed the results of the med pass observation. The surveyor asked the U.S. FOIA if it was an expectation for the staff to administer meds on time and to follow the PO as they were in the medical record. The U.S. FOIA stated yes, it was expected that the meds should be given on time and as the PO. A review of the facility's "Administering Medications Policy," with a revision date of April 2019, reflected, under line 4. Meds are administered in accordance with prescribed orders, including any required time frame. Line 7. Meds are administered within one hour of their prescribed time, unless otherwise specified (for example, before and after meal orders). The U.S. FOIA (did not provide any further pertinent information. N.J.A.C 8:39-29.2 (d)	F0759		
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. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.	F0812	1. WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS AFFECTED BY THE DEFICIENT PRACTICE The two rectangular pans identified as wet nesting were immediately removed from circulation and the 3 dented cans identified were immediately removed from the dry storage shelves and placed in the dented can area on 8/5/25 by the FSD. On 8/7/25, all unlabeled items identified in the 3rd floor nourishment room refrigerator and freezer were discarded by the LPN/UM. The ice buildup in the 3rd floor nourishment room freezer was removed by the Dietary Aide. On 8/7/25, Resident #64 was evaluated by the LPN/UM. Resident #64 denied NJ Ex Order 26. NJ Ex Order 26.(and other NJ E . The provider was made of the expired open bottle of mustard. 2. HOW WILL THE FACILITY IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THIS SAME DEFICIENT PRACTICE All residents have the potential to be affected by this deficient practice.	08/8/2025

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F0812 SS = F	Continued from page 56 This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to handle potentially hazardous foods and maintain kitchen sanitation practices as well as store, and label in a manner intended to prevent the spread of food borne illness. This deficient practice was evidenced by the following: On 8/5/25 at 9:29 AM, the surveyor in the presence of the U.S. FOIA (b) (6) observed the following during the initial kitchen tour: 1. Two rectangular pans wet nesting on the racks. The surveyor asked when the pans were washed and the U.S. FOIA responded, "They were washed last night." The U.S. FOI confirmed the wet nesting on the pans and stated, "I'm obviously upset right now and will talk to US FO " 2. In the dry storage room: two cans of stewed tomatoes each dented half an inch on the side; and one can of creamed corn observed with lip dented. The U.S. FOI stated that the expectation was if anything was dented, it shoul be on the dented can area and that the Porter would be spoken to about the incident. The U.S. FOI further stated that he and the U.S. FOIA (were responsible for checking the cans every Tuesday and Wednesday, and the cook would check it when grabbing something off the shelves every day. On 8/7/25 at 11:11 AM, the surveyor toured the 3rd floor nursing unit nourishment room in presence of the U.S. FOIA (b) (6) Both the surveyor and U.S. FOIA (b) (6) observed a posted signage on the door of the refrigerator (ref), "All food must be dated and have resident's name. Dated food will be discarded after 3 days. Any undated item will be thrown away. Employees must use employee lounge ref." The surveyor and the U.S. FOIA (b) (6) also observed the following:The freezer temperature (temp) at minus 10 F (fahrenheit) degrees with thick ice accumulation on the entire bottom of the freezer.American beef patty inside a plastic not labeled with a resident name or dated.Four mini apple pie not labeled with resident name or dated.An open mustard bottle labeled with name of Resident #64, no date when bottle was opened. The mustard bottle had a best used by date of 7/2025. At that same time, the surveyor asked the U.S. FOIA (b) (6) what the process was for storing food in the freezer and ref and how the freezer should be maintained. The U.S. FOIA (b) (6) confirmed that there	F0812	Continued from page 56 3. WHAT MEASURES WILL BE PUT IN PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT OCCUR The Administrator or designee in-serviced all active dietary employees of the facility's Sanitation Policy, Food Receiving and Storage-Dry Food Storage Policy, and Use and Storage of Food Brought in by Family or Visitors Policy. The Food Service Director (FSD) or designee will audit the pan drying rack and the dry storage area for dented cans daily x 30 days then 3x weekly x 3 months to ensure compliance daily x 30 days. The FSD or designee will audit the nursing unit nourishment rooms weekly x 4 weeks then monthly for 3 months to ensure all items stored in the fridge and freezer are labeled with the resident's name and date, discarded after 3 days, and no ice build in the freezers. 4. HOW WILL THE FACILITY MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR The FSD will report the results of the audit at monthly QAPI meetings x 4 months to ensure compliance or if further actions are necessary.	

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F0812 SS = F	Continued from page 57 should be no freezer ice build up, the beef patty and pie should be labeled with resident's name and dated. The U.S. FOIA (b) (6) further stated that the mustard should not be in there because it was expired. The surveyor asked the U.S. FOIA (b) (6) whose responsibility was to keep the freezer/ref cleaned and to check that food were labeled and not expired, and she responded, "The kitchen is in charge of keeping the ref cleaned and making sure nothing is expired and everything is labeled." On 8/7/25 at 12:34 PM, the surveyor interviewed the U.S. FOI on who was responsible for the nourishment rooms in the units. The U.S. FOI responded, "My staff goes up in the morning, check the temp and is responsible for cleaning ref and freezer. In the past it's always been maintenance who unplugs and defrost the freezer. The U.S. FOI further stated that it was the responsibility of nursing department to ensure food were labeled and dated. The U.S. FOI also stated that their department was in charge of the bottles expiration dates. The U.S. FOI confirmed that there should be no ice build up in the ref or freezer. At that same time, the surveyor showed the picture of the ice buildup in the freezer. The U.S. FOI responded, “It does not seem it happened overnight.” On 8/7/25 at 1:36 PM, the survey team met with the U.S. FOIA (b) (6)) and the U.S. FOIA (b) (6)), and the surveyor notified them of the above findings and concerns. The U.S. FOIA (provided in service and education and the U.S. FOIA (confirmed it was done after surveyor's inquiry. A review of the facility's "Sanitization Policy", under Policy Statement: The food service area is maintained in a clean and sanitary manner... Policy Interpretation and Implementation...#7. Food preparation equipment and utensils that are manually washed are allowed to air dry whenever practical... A review of the facility's "Food Receiving and Storage-Dry Food Storage Policy", goods are handled and stored in a matter that maintains the integrity of the packaging until they are ready to use... A review of the facility's "Use and Storage of Food Brought in by Family or Visitors Policy", under Policy Explanation and Compliance Guidelines... #2. All food items that are already prepared by the family or visitor brought in must be labeled with content and dated...	F0812		

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F0812 SS = F	Continued from page 58 NJAC 8:39-17.2(g)	F0812		
F0814 SS = D	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to provide a sanitary environment for residents, staff, and the public by failing to, a.) cover the garbage container and b.) keep the garbage container area free of garbage and debris. This deficient practice was identified for 1 of 1 garbage containers. This was evidenced by: On 8/5/25 at 10:20 AM, in the presence of the U.S. FOIA [redacted] the surveyor toured the loading dock and dumpster area. Both the surveyor and the U.S. FOI observed the compactor was currently being dropped off. The U.S. FOIA (b) (6) [redacted]), who stated that the compactor was being picked up every other week on Thursdays. On 8/6/25 at 12:58 PM, the surveyor and the U.S. FOI toured the refuse/dumpsters area and observed the following: 1. The uncovered compactor filled with cardboard boxes and regular garbage. 2. Gloves, water bottles, and loose trash inside the bottom floor of the compactor. 3. Five spots of animal feces on the landing area of the facility near the opening part of the compactor. At that same time, the U.S. FOI stated, "The garbage for cardboard and the regular garbage are not separated, all garbage of the facility goes all in one compactor. It's always been like that, not covered, cannot close it because of the metal part. It's always been an open dumpster, it should not be that way, housekeeping is in charge of keeping the area clean." The U.S. FOIA (b) (6) [redacted]) and U.S. FO confirmed the open compactor and garbage around the area. The U.S. FO stated that the compactor did not close and that was how it was designed. The U.S. FO also stated "this is what we have." The surveyor asked, why was it important to keep it closed, and the U.S. FO replied, "So animals cannot get in	F0814	1. WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS AFFECTED BY THE DEFICIENT PRACTICE On 8/7/25, the garbage compactor was removed and replaced with a fully enclosed dumpster until the original compactor could be modified to allow full enclosure. On 8/14/25, the original compactor was delivered. It was modified to allow full enclosure. On 8/7/25, the area around the garbage container was cleaned to ensure there is no garbage and debris. 2. HOW WILL THE FACILITY IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THIS SAME DEFICIENT PRACTICE All residents have the potential to be affected by this deficient practice. 3. WHAT MEASURES WILL BE PUT IN PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT OCCUR On 8/6/25, the Housekeeping Director (HD) in-serviced the housekeeping staff to monitor and maintain the compactor/dumpster area 2 times a day to ensure appropriate sanitation. The HD or designee will monitor the outdoor compactor area daily x 30 days than 3 times a week x 3 months to ensure sanitation. 4. HOW WILL THE FACILY MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR Audit results will be monitored by the Administrator at monthly QAPI meetings x 4 months to ensure compliance or if further actions are necessary.	10/8/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315386	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLAS REHABILITATION AND HEALTHCARE AT MAYWOOD	100 WEST MAGNOLIA AVENUE , MAYWOOD, New Jersey, 07607

(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
F0814 SS = D	Continued from page 59 it." The U.S. FOI further stated that it was mentioned over the years and about two month ago to the U.S. FOIA (b) (6) about the dumpster. On 8/6/25 at 1:10 PM, the surveyor toured the refuse area with the U.S. FOIA (and the U.S. FOIA The U.S. FOIA (observed and confirmed the compactor area was open and confirmed animal feces on the landing. The surveyor asked, what was the expectation for this area as far as sanitation, and the U.S. FOIA (responded, "The expectation is to keep the dumpster closed to keep animals out." The surveyor requested for the facility policy for refuse/garbage area. On 8/7/25 at 1:00 PM, the U.S. FOIA (and the U.S. FOIA (b) (6) toured the refuse area. The U.S. FOIA stated, "We sent the compactor back, they're going to put a lid on it, they gave us a temporary dumpster with a lid. We cleaned up the area and did some education with the staff." The surveyor observed the refuse area and found a new dumpster with a lid, observed the surrounding area with used disposal gloves and debris on the ground. The U.S. FOIA (stated, "They just took the compactor and still have to clean the grounds." The surveyor stated the concerns were the uncovered compactor, loose garbage and the animal feces on the landing. The surveyor asked the U.S. FOIA if he saw those yesterday and he confirmed he saw those things yesterday, "I understand the concern with the uncovered refuse and the animal feces." On 8/7/25 at 1:36 PM, the survey team met with the U.S. FOIA (and the U.S. FOIA (b) (6)) to discuss the concerns above. A review of the facility's "Disposal of Garbage and Refuse Policy" which revealed: Garbage shall be disposed of in refuse containers with plastic liners and lids...Surrounding area shall be kept clean.... refuse shall be.... cleaned at a frequency necessary to prevent.....becoming attractants for insects and rodents. A review of the facility's "Sanitization Policy"...Policy Statement: #14 Garbage and refuse containers are in good condition, without leaks, and waste is properly contained in dumpsters/compactors with lids (or otherwise covered). On 8/8/25 at 12:36 PM, the U.S. FOIA (b) (6)), provided the facility responses in writing and revealed: Refuse: Upon administrator notification on 8/6/25, the	F0814		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315386	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLAS REHABILITATION AND HEALTHCARE AT MAYWOOD	100 WEST MAGNOLIA AVENUE , MAYWOOD, New Jersey, 07607

(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
F0814 SS = D	Continued from page 60 loading dock was cleared of all items, and the floor was mopped, stripped, and waxed. [Name Redacted] was immediately contacted for immediate resolution. New, fully enclosed dumpster was delivered on 8/7/25 at 10:30 AM....until the original compactor can be modified to allow for full enclosure.... housekeeping staff in-serviced to check loading dock 2x (times) daily to maintain cleanliness. Signs were hung inside the loading dock as a reminder to the housekeeping staff. Copy of in-service signage "Loading dock and outside surrounding area...." dated 8/7/25 provided. On 8/8/25 at 12:54 PM, the survey team met with the U.S. FOIA (b) (6)), U.S. FOIA (and the U.S. FOIA and the U.S. FOIA (stated that "we have" temporary dumpster with a lid and the area was cleaned. The U.S. FOIA (further stated that the dumpster would be maintained closed, housekeeping will be inspecting the loading dock area twice daily to clean. The U.S. FOIA (added that the Housekeeping was responsible for cleaning the area. The U.S. FOIA (b) (stated that would be included in their Quality Assurance Performance Improvement (QAPI). NJAC 8:39-19.3(a)(c),31.5(a)1,2	F0814		
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;	F0880	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR RESIDENTS AFFECTED BY THE DEFICIENT PRACTICE On 8/6/25, alcohol-based hand rub was immediately placed at the front desk for use and disinfecting wipes to clean the kiosk as needed. HOW WILL THE FACILITY IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THIS SAME DEFICIENT PRACTICE All residents, staff, and anyone entering the facility have the potential to be affected by this deficient practice. HOW WILL THE FACILITY IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THIS SAME DEFICIENT PRACTICE The Housekeeping Director (HD) or designee in-serviced the housekeeping staff and front desk receptionists on the facility's Handwashing/Hand Hygiene Policy and Routine Cleaning and Disinfection Policy. The IP or designee will audit and ensure alcohol-based hand rub is available at the reception desk daily x 2	09/12/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315386	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLAS REHABILITATION AND HEALTHCARE AT MAYWOOD	100 WEST MAGNOLIA AVENUE , MAYWOOD, New Jersey, 07607

(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
F0880 SS = D	Continued from page 61 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by:	F0880	Continued from page 61 weeks, then weekly x 2 weeks, then monthly x 3 months to ensure the availability of alcohol-based hand rub and disinfectant wipes at the reception. HOW WILL THE FACILY MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR The HD will report the results of the audits at the monthly QAPI meetings x 4 months to ensure compliance or if further actions are necessary.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315386	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLAS REHABILITATION AND HEALTHCARE AT MAYWOOD	100 WEST MAGNOLIA AVENUE , MAYWOOD, New Jersey, 07607

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F0880 SS = D	Continued from page 62 Based on observation, interview, and review of facility documentation, the facility failed to maintain infection control practices to reduce the risk of infection, specifically by failing to ensure Alcohol Based Hand Rub (ABHR) was available to perform hand hygiene (HH) upon entering the facility and for use before and after signing in on the kiosk or provide disinfecting wipes to clean the kiosk after each use in between visitors. This deficient practice was observed for 2 of 5 days. This deficient practice was evidenced by the following: Reference: Centers for Disease Control (CDC) under the Healthcare-Associated Infections (HAIs) topic; Best Practices for Environmental Cleaning in Global Healthcare Facilities with Limited Resources with an updated date of March 19, 2024, at https://www.cdc.gov/healthcare-associated-infections/hcp/cleaning-global/introduction.html, included the following: As seen in Figure 1, colonized or infected patients can contaminate environmental surfaces and noncritical equipment. Microorganisms from these contaminated environmental surfaces and noncritical equipment can be transferred to a susceptible patient in two ways: If the susceptible patient makes contact with the contaminated surfaces directly (e.g., touches them). If healthcare personnel, a caretaker, or visitor makes contact with the contaminated surfaces and then transfers the microorganisms to the susceptible patient. Contaminated hands or gloves of healthcare personnel, caretakers, and visitors can also contaminate environmental surfaces in this way. Proper hand hygiene and environmental cleaning can prevent transfer of microorganisms to healthcare personnel, caretakers, and visitors and to susceptible patients. Evidence is increasing but remains limited that effective environmental cleaning strategies reduce the risk of transmission and contribute to outbreak control…Consequently, the use of multiple (i.e., a bundle) interventions as well as an overall multi-modal approach to IPC activities and programs is recommended, for both the outbreak and routine settings. On 8/5/25 at 9:00 AM, the survey team entered the facility. The survey team did not observe ABHR or disinfecting wipes in the front area of the facility or	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315386	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLAS REHABILITATION AND HEALTHCARE AT MAYWOOD	100 WEST MAGNOLIA AVENUE , MAYWOOD, New Jersey, 07607

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F0880 SS = D	Continued from page 63 near the kiosk that was utilized for visitors to sign in on. On 8/6/25 at 9:00 AM, the surveyor entered the facility. The surveyor observed a kiosk that the U.S. FOIA (b) (6) instructed the surveyor to sign in. The surveyor observed that there was not an ABHR dispenser in the area of the kiosk. The surveyor used their own ABHR prior to signing in on the kiosk and again used their own ABHR after signing in. The surveyor also observed that there were no disinfecting wipes located in the area to clean the kiosk after use. The Receptionist did not encourage the surveyor to perform HH. On 8/6/25 at 12:16 PM, the surveyor interviewed the U.S. FOIA (b) (6)) regarding the process for visitors entering the facility and the kiosk. The U.S. FOIA (b) (6) stated that when visitors entered the facility that they were encouraged to use ABHR. He added that there were ABHR stations throughout the facility. He added that there were hand washing signs in the elevator and the dayrooms. The U.S. FOIA (b) (6) stated that there was a ABHR station at the kiosk at the entrance. On 8/6/25 at 12:25 PM, the surveyor asked the U.S. FOIA (b) (6) to show the surveyor where the ABHR station was located at the entrance. The U.S. FOIA (b) (6) confirmed that the ABHR station was empty and did not contain ABHR and that there was no bottle of ABHR on the front desk near the kiosk or anywhere in the entrance area of the facility. The Receptionist also confirmed that there was no ABHR located on the front desk or in the area of the entrance. The U.S. FOIA (b) (6) then retrieved a bottle of ABHR from his office and placed it on the front desk. The U.S. FOIA (b) (6) stated that there should have been ABHR on the front desk. The surveyor asked for the facility's policy regarding visitors, hand hygiene and the kiosk. On 8/6/25 at 12:54 PM, the U.S. FOIA (b) (6)) provided the surveyor a policy regarding HH and stated that she did not have a specific policy related to the kiosk. On 8/7/25 at 10:57 AM, the surveyor interviewed the U.S. FOIA (b) (6) regarding cleaning of the kiosk. The U.S. FOIA (b) (6) stated that she did not do anything with the kiosk. She added that she just told the visitors to sign in. The U.S. FOIA (b) (6) stated that she left at 4:30 PM and that she thought that housekeeping may clean it.	F0880		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLAS REHABILITATION AND HEALTHCARE AT MAYWOOD	100 WEST MAGNOLIA AVENUE , MAYWOOD, New Jersey, 07607

(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
F0880 SS = D	Continued from page 64 On 8/7/25 at 10:59 AM, the surveyor interviewed the U.S. FOIA (b) (6) regarding cleaning the kiosk. The U.S. FOIA (b) (6) stated that it should be cleaned between uses and that he would place wipes there. On 8/7/25 at 11:35 AM, the surveyor interviewed the U.S. FOIA (b) (6) regarding visitors, HH and kiosk. The U.S. FOIA stated that the U.S. FOIA (b) (6) asked visitors to sign in on the kiosk and that visitors were encouraged to perform HH. The surveyor asked the U.S. FOIA if the kiosk was a high touch area and how it was cleaned. The U.S. FOIA confirmed that it was a high touch area and that she had to check regarding the cleaning. On 8/7/25 at 1:08 PM, the U.S. FOIA provided the surveyor a policy regarding routine cleaning and disinfection. The U.S. FOIA stated that the kiosk was part of the routine cleaning schedule of the front area. The kiosk was wiped down by the housekeeper daily and as needed. On 8/7/25 at 1:41 PM, the surveyor notified the U.S. FOIA (b) U.S. FOIA and U.S. FOIA (b) (6) the concern that the entrance area did not have ABHR for visitors to use upon entrance and prior to using the kiosk to sign in and there were no disinfecting wipes to clean the kiosk screen between uses. The U.S. FOIA (stated that there was usually a bottle of ABHR at the front desk. On 8/8/25 at 12:59 PM, in the presence of the U.S. FOIA and U.S. FOIA (b) (6) the U.S. FOIA (stated that she interviewed the U.S. FOIA (b) (6) and that she said the ABHR was there on Monday (8/4/25) and Tuesday (8/5/25). The U.S. FOIA (stated that she had a whole box of bottles of ABHR delivered to the front desk and that kiosk was part of the housekeeping routine cleaning and that the kiosk was wiped at the beginning of the day. The U.S. FOIA (did not provide any additional information. A review of the facility's “Handwashing/Hand Hygiene Policy” with a revised date of October 2023, included the following: Policy Statement This facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections. Policy Interpretation and Implementation Administrative Practices to Promote Hand Hygiene	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315386	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLAS REHABILITATION AND HEALTHCARE AT MAYWOOD	100 WEST MAGNOLIA AVENUE , MAYWOOD, New Jersey, 07607

(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
F0880 SS = D	Continued from page 65 1. All personnel are trained and regularly in-service on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. 2. All personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents, and visitors. 3. Hand hygiene products and supplies (sinks, soap, towels, alcohol-based hand rub, etc.) are readily accessible and convenient for staff use to encourage compliance with hand hygiene policies. ABHR dispensers are placed in areas of high visibility and consistent with workflow throughout the facility… 6. Residents, family members and/or visitors are encouraged to practice hand hygiene. Fact sheets, pamphlets and/or other written materials promoting hand hygiene practices are provided at the time of admission and/or posted throughout the facility. A review of the facility's “Routine Cleaning and Disinfection Policy” with a copyright date of 2023, included the following: Policy: It is the policy of this facility to ensure the provision of routine cleaning and disinfection in order to provide a safe, sanitary environment and to prevent the development and transmission of infections to the extent possible. Definitions: “Disinfection” refers to thermal or chemical destruction of pathogenic and other types of microorganisms. “Hand Hygiene” refers to a general term that applies to hand washing, antiseptic wash and ABHR. “Standard Precautions” refer to the infection prevention practices that apply to all residents, regardless of suspected or confirmed diagnosis or presumed infection status. Policy Explanation and Compliance Guidelines: 1. Routine cleaning and disinfection of frequently touched or visibly soiled surfaces will be performed in common areas… 4. Routine surface cleaning and disinfection will be	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315386	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLAS REHABILITATION AND HEALTHCARE AT MAYWOOD	100 WEST MAGNOLIA AVENUE , MAYWOOD, New Jersey, 07607

(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
F0880 SS = D	Continued from page 66 conducted with a detailed focus on visibly soiled surfaces and high touch areas to include, but not limited to:… h. Monitor control panels, touch screens… N.J.A.C. 8:39-19.4	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 60203	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLAS REHABILITATION AND HEALTHCARE AT MAYWOOD	100 WEST MAGNOLIA AVENUE , MAYWOOD, New Jersey, 07607

(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
S0000	Initial Comments 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.	S0000		08/19/2025
S0560	Mandatory Access to Care CFR(s): 8:39-5.1(a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This LICENSURE REQUIREMENT is NOT MET as evidenced by: REPEAT DEFICIENCY Based on interview, and review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios for 10 of 14 day shifts as mandated by the state of New Jersey. This deficient practice was evidenced by the following: Reference: NJ State requirement, CHAPTER 112. An Act concerning staffing requirements for nursing homes and supplementing Title 30 of the Revised Statutes. Be It Enacted by the Senate and General Assembly of the State of New Jersey: C.30:13-18 Minimum staffing requirements for nursing homes effective 2/1/21. 1. a. Notwithstanding any other staffing requirements as may be established by law, every nursing home as defined in section 2 of P.L.1976, c.120 (C.30:13-2) or licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et	S0560	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THE RESIDENTS AFFECTED BY THE DEFICIENT PRACTICE No residents were found to be affected by this deficient practice. The facility conducted a root cause analysis and identified last-minute call outs as the contributing factor affecting staffing ratios. HOW WILL THE FACILITY IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THIS SAME DEFICIENT PRACTICE All Residents have the potential to be affected by this deficient practice. WHAT MEASURES WILL BE PUT IN PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT OCCUR On 8/19/25, the administrator in-serviced the staffing coordinator on the State of New Jersey required minimum direct care staff-to-resident ratios. Online recruitment ads monitored daily for FT, PT, and PD shifts Referral bonus offered to existing staff. Marketing in Local colleges and CNA programs to	09/12/2025

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: 60203	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLAS REHABILITATION AND HEALTHCARE AT MAYWOOD	100 WEST MAGNOLIA AVENUE , MAYWOOD, New Jersey, 07607

(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
S0560	Continued from page 1 seq.) shall maintain the following minimum direct care staff -to-resident ratios: (1) one certified nurse aide to every eight residents for the day shift; (2) one direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be certified nurse aides, and each staff member shall be signed in to work as a certified nurse aide and shall perform certified nurse aide duties; and (3) 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 certified nurse aide and perform certified nurse aide duties b. Upon any expansion of resident census by the nursing home, the nursing home shall be exempt from any increase in direct care staffing ratios for a period of nine consecutive shifts from the date of the expansion of the resident census. c. (1) The computation of minimum direct care staffing ratios shall be carried to the hundredth place. (2) If the application of the ratios listed in subsection a. of this section results in other than a whole number of direct care staff, including certified nurse aides, for a shift, the number of required direct care staff members shall be rounded to the next higher whole number when the resulting ratio, carried to the hundredth place, is fifty-one hundredths or higher. (3) All computations shall be based on the midnight census for the day in which the shift begins. d. Nothing in this section shall be construed to affect any minimum staffing requirements for nursing homes as may be required by the Commissioner of Health for staff other than direct care staff, including certified nurse aides, or to restrict the ability of a nursing home to increase staffing levels, at any time, beyond the established minimum ... A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the two-week period beginning 7/20/2025 and ending 8/2/2025 revealed the facility was not in compliance with the State of New Jersey minimum staffing requirements.	S0560	Continued from page 1 increase local community recruitment Nursing leadership utilized in CNA capacity as needed to offset needs. Sign on bonuses offered. Bonuses offered to staff for extra shifts worked. The DON/Designee will meet with the staffing coordinator daily to review census vs. staffing needs and call outs x 30 days. HOW WILL THE FACILITY MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR The DON or designee will audit staffing ratios compliance weekly x 3 months and the results of the audits at monthly QAPI committee x3 months to ensure compliance and if further actions are necessary.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 60203	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLAS REHABILITATION AND HEALTHCARE AT MAYWOOD	100 WEST MAGNOLIA AVENUE , MAYWOOD, New Jersey, 07607

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S0560	Continued from page 2 The facility was deficient in CNA staffing for residents on 10 of 14 day shifts as follows: -07/20/25 had 13 CNAs for 109 residents on the day shift, required at least 14 CNAs. -07/21/25 had 11 CNAs for 109 residents on the day shift, required at least 14 CNAs. -07/24/25 had 12 CNAs for 108 residents on the day shift, required at least 13 CNAs. -07/26/25 had 13 CNAs for 111 residents on the day shift, required at least 14 CNAs. -07/27/25 had 10 CNAs for 110 residents on the day shift, required at least 14 CNAs. -07/28/25 had 13 CNAs for 110 residents on the day shift, required at least 14 CNAs. -07/29/25 had 13 CNAs for 110 residents on the day shift, required at least 14 CNAs. -07/30/25 had 12 CNAs for 109 residents on the day shift, required at least 14 CNAS. -07/31/25 had 13 CNAs for 109 residents on the day shift, required at least 14 CNAs. -08/02/25 had 12 CNAs for 109 residents on the day shift, required at least 14 CNAs. On 8/11/2025 at 1:00 PM, the surveyor notified the Licensed Nursing Home Administrator, the Director of Nursing, the Regional Director of Clinical Services, and the Regional Director of Operations about the above concerns for minimum staffing ratios not being met. A review of the facility's "Staffing, Sufficient and Competent Nursing Policy" with a last revised date of August 2022, under Policy Interpretation and Implementation indicated...2. Staffing numbers and the skill requirements of direct care staff are determined by the needs of the residents based on each resident's plan of care, the resident assessments and the facility assessment...8. Minimum staffing requirements imposed by the state, if applicable, are adhered to when determining staff ratios…"	S0560		
S1405	Mandatory Infection Control and Sanitation	S1405	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE	09/12/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 60203	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/11/2025

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S1405	Continued from page 3 CFR(s): 8:39-19.5(a) The facility shall require all new employees to complete a health history and to receive an examination performed by a physician or advanced practice nurse, or New Jersey licensed physician assistant, within two weeks prior to the first day of employment or upon employment. If the new employee receives a nursing assessment by a registered professional nurse upon employment, the physician's or advanced practice nurse's examination may be deferred for up to 30 days from the first day of employment. The facility shall establish criteria for determining the completeness of physical examinations for employees. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and a review of pertinent facility documents, it was determined that the facility failed to ensure that a newly hired employee completed a health history and received an examination by a physician, an advanced practice nurse, or a licensed physician assistant within two weeks prior to the first day of employment or upon employment for 2 of 10 (Staff #1 and #2) new employee files reviewed. This deficient practice was evidenced by the following: The surveyor reviewed ten randomly selected newly hired employee files. The review for physical examinations for 2 of the 10 new employees revealed the following: Staff #1, a Licensed Practical Nurse, hired on [redacted], had a physical examination signed by a physician on [redacted]. Staff #2, a Certified Nurse Aide, hired on [redacted], had a physical examination signed by a physician on [redacted]. On 8/8/25 at 11:04 AM, the surveyor interviewed the Human Resources (HR) staff who stated he was responsible for overseeing that physical examinations were completed during the hiring process and coordinated with the staff educator. The surveyor reviewed with the HR staff the physical examinations of	S1405	Continued from page 3 RESIDENTS AFFECTED BY THE DEFICIENT PRACTICE No residents were affected by this deficient practice. Staff #1 began on-line onboarding paperwork on [redacted] but did not physically enter the facility until [redacted]. Staff #1 did not enter the facility, nor have any contact with residents, on [redacted]. Staff #1 received a physical from the Medical Director on [redacted]. Staff #2 received an initial physical examination by the facility educator/RN (Registered Nurse) on date of hire [redacted]. Staff #2 received a physical examination by the Medical Director on [redacted]. The facility educator/RN (Registered Nurse) was performing initial physical assessments of new hire employees upon orientation, and the Medical Director completed an assessment within 30 days. After review of the forms, it was identified that the form did not offer separate signature and date lines for the RN and the Medical Director. On 8/20/25, the form was updated to allow for RN signature and date as well as MD signature and date. HOW WILL THE FACILITY IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THIS SAME DEFICIENT PRACTICE All residents assigned to new hire employees have the potential to be affected by this deficient practice. WHAT MEASURES WILL BE PUT IN PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT OCCUR On 8/19/25, the Administrator in-serviced the Human Resource Director (HRD) and facility's educator on the facility's Employee Health Program Policy. On 8/19/25, an Employee Physical form was updated to contain separate signature sections for the RN assessment and Physician assessment. The HRD or designee will audit all new hire health files weekly x 1 month, then monthly x 3 months to ensure compliance with physical completion and timing regulations. HOW WILL THE FACILITY MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 60203	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/11/2025

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ATLAS REHABILITATION AND HEALTHCARE AT MAYWOOD	100 WEST MAGNOLIA AVENUE , MAYWOOD, New Jersey, 07607

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S1405	Continued from page 4 Staff #1 and Staff #2 being completed after their listed date of hire. The HR staff provided no verbal response. The surveyor asked what the facility's policy for the completion of new hire physicals was. The HR staff stated he would get back to the surveyor with a response. On 8/8/25 at 1:40 PM, the surveyor notified the Licensed Nursing Home Administrator (LNHA), the Director of Nursing (DON), and the Regional Director of Clinical Services (RDoCS) of the concern for the two staff physicals being completed after their date of hire. On 8/11/25 at 11:43 AM, the LNHA, the DON, and the RDoCS met with the survey team. The LNHA stated regarding Staff #1 that they did not come in until NJ Ex Order and that was her date of hire. The surveyor notified the LNHA that the new hire list and provided files indicated a hire date of NJ Ex Order 26 The LNHA stated that was was due to new hires completing online training and that her actual first day on-site was NJ Ex Order. The surveyor asked what the facility's policy for completion of physicals for new hires was and the LNHA replied they were conducted by the hire date and the physician had 30 days from the staff's hire date to complete it. At that same time, the surveyor asked the LNHA, DON, and the RDoCS if their policy was according to state regulations. The LNHA replied yes that it was part of the state regulation. The surveyor reviewed the state regulation which indicated physicals to be completed upon hire by a a physician or a Registered Nurse (RN) assessment could be conducted 2 weeks or upon hire in which the physician would have 30 days to complete. The LNHA indicated the staff educator was responsible and reviewed the physicals with the physician. The surveyor asked the LNHA if the physical forms indicated the RN completed an assessment. The LNHA stated the date at the top of the form was when the RN conducted the assessment. A review of the form did not reveal a separate assessment from the physician conducted by the RN or a signature by the RN acknowledging an assessment was conducted. There was no additional response provided by the facility. A review of the facility's undated "Employee Physicals Policy" revealed under Policy Interpretation and Implementation:…2. Each potential employee who has received a conditional offer of employment will be required to undergo a physical examination and answer	S1405	Continued from page 4 AND WILL NOT RECUR The HRD will report the findings of the audits to the monthly QAPI meetings x 4 months to ensure compliance or if further actions are necessary.	

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S1405	Continued from page 5 any inquires related to his/her medical status… A review of the facility's "Medical Examinations (Physicals) Policy" with a last revised date of January 2008 revealed under Policy Statement…Each potential employee, after receiving a conditional offer of employment, and each current employee whose job position necessitates such must undergo physical examinations. Under Policy Interpretation and Implementation:… 2. Each potential employee who has received a conditional offer of employment will be required to undergo a physical examination and answer any inquires related to his/her medical status... The policy did not further address the timeframe for which physicals should be completed for new hire staff.	S1405		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315386	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/23/2025

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F0000	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted on 9/23/2025 in relation to the 8/11/2025 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 60203	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/23/2025

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S0000	Initial Comments An offsite/desk review of the facility's Plan of Correction was conducted on 9/23/2025 in relation to the 8/11/2025 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: 315386	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - NEW BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/11/2025

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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 08/05/25 and 08/06/25. Atlas Rehabilitation and Healthcare at Maywood 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 Occupancies. Atlas Rehabilitation and Healthcare at Maywood is a three-story building built in 2008 and is composed of Type II (222) construction. The facility is divided into nine - smoke zones. The 300KW diesel generator powers approximately 80 % of the building per the Maintenance Director. The current occupied beds were 111 of 120.	K0000		08/19/2025
K0211 SS = E	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This STANDARD is NOT MET as evidenced by: Based on observations and interview on 08/05/2025 in the presence of the U.S. FOIA (b) (6)) and the U.S. FOIA (b) (6) from a sister facility U.S. FOIA (b)), it was determined that the facility failed to ensure means of egress were continuously maintained free of all obstructions to full use in case of emergency in accordance with NFPA 101: 2012 Edition, Section 19.2.1 and 7. This deficient practice had the potential to	K0211	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THE RESIDENTS AFFECTED BY THE DEFICIENT PRACTICE All items stored in the West and South wing exit access corridors were immediately removed by the Maintenance Director. The Administrator re-educated the Housekeeping and Maintenance staff that corridors and means of egress must be continuously maintained free of all obstructions. HOW WILL THE FACILITY IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THIS SAME DEFICIENT PRACTICE All residents in the facility have the potential to be affected by this deficient practice. WHAT MEASURES WILL BE PUT IN PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT	08/19/2025

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: 315386	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - NEW BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/11/2025

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K0211 SS = E	Continued from page 1 affect 50 of 111 residents and was evidenced by the following: An observation at 10:25 AM revealed that the West wing exit access corridor was being used as a storage area for over 35 boxes on a pallet that reduced corridor to approximately three-foot wide. In an interview at the time, the U.S. FO and the U.S. FOIA (b confirmed the finding. An observation at 10:55 AM revealed that the South wing exit access corridor was being used as a storage area for four beds, mattresses, wheelchairs and boxes on three pallets that reduced corridor to approximately three-foot wide. In an interview at the time, the U.S. FO and the U.S. FOIA (b confirmed the finding. The facility's U.S. FOIA (b) (6) U.S. FOIA (b) (6) and U.S. FOIA (b) (6) were notified of the deficient practice at the Life Safety Code survey exit conference on 08/06/2025 at 2:47 PM. N.J.A.C. 8:39-31.2(e)	K0211	Continued from page 1 OCCUR The Maintenance Director educated all housekeeping staff and department managers on Life Safety Code (LSC) requirements for maintaining clear egress pathways. A designated staging/storage area has been created for supplies and equipment, preventing the need to use corridors for storage. New supply or equipment deliveries will be coordinated with the Maintenance Director or designee to ensure corridors remain clear of obstructions. The Maintenance Director audited all facility egress corridors to ensure they remain free of all obstructions. HOW WILL THE FACILITY MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR The Maintenance Director or designee will conduct weekly corridor audits for three (3) weeks, then monthly audits for three (3) months. Any findings will be immediately corrected and reported to the Administrator. The Administrator or designee will review the results of these audits at the facility's monthly Quality Assurance and Performance Improvement (QAPI) meeting for a minimum of three months. If continued compliance is demonstrated, audits may transition to routine environmental rounds.	
K0222 SS = F	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	K0222	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR RESIDENTS AFFECTED BY THE DEFICIENT PRACTICE The Maintenance Director immediately disengaged the hook-type deadbolt locksets on both sets of sliding doors at the facility main entrance. After lock removal, the sliding doors were tested and verified to be fully operable and free of all obstructions and impediments. HOW WILL THE FACILITY IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THIS SAME DEFICIENT	08/22/2025

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K0222 SS = F	Continued from page 2 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 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	K0222	Continued from page 2 PRACTICE All residents have the potential to be affected by this deficient practice. WHAT MEASURES WILL BE PUT IN PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT OCCUR The Maintenance Director reviewed all facility egress doors to ensure compliance with National Fire Protection Association (NFPA) 101 requirements for unobstructed, readily accessible egress. The Administrator re-educated the Maintenance staff on inspecting and maintaining all egress doors to ensure they remain readily accessible and free of obstructions and impediments. HOW WILL THE FACILITY MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR The Maintenance Director or designee will conduct weekly audits for three (3) weeks of facility egress doors to ensure they remain free of obstructions and impediments. Following the initial period, the Maintenance Director will continue audits monthly for three (3) months. The Administrator or designee will review the findings in the monthly Quality Assurance and Performance Improvement (QAPI) Committee meeting for a minimum of three months, with continuation as needed.	

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ATLAS REHABILITATION AND HEALTHCARE AT MAYWOOD	100 WEST MAGNOLIA AVENUE , MAYWOOD, New Jersey, 07607

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K0222 SS = F	Continued from page 3 This STANDARD is NOT MET as evidenced by: Based on observations documentation review and interview on 08/05/2025 in the presence of the U.S. FOIA (b) (6)) and the (b) (9) from a sister facility (U.S. FOIA (b) (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 NFPA 101:2012 Edition, Section 19.2.2.2.5.1, 19.2.2.2.5.2 and 19.2.2.2.6. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 9:30 AM at the main entrance with the U.S. Fo and the U.S. FOIA (b) revealed that the outer set of sliding doors and the inner set of sliding doors had a lockset that engaged a hook-type deadbolt that could restrict emergency use of the exit. The sliding doors had signs indicating push to open in an emergency, but with the thumb-latch locks engaged, this procedure would not open the doors as stated on the signs. The U.S. Fo tested the doors by locking and pushed to open, but he could not open the doors. A review of the current evacuation plan revealed that the front doors were designated an exit/egress route. In an interview at the time, the U.S. Fo and the U.S. FOIA (b) confirmed the observation. The facility's U.S. FOIA (b) (6) U.S. FOIA (b) (6) and U.S. FOIA (b) (6) were notified of the deficient practice at the Life Safety Code survey exit conference on 08/06/2025 at 2:47 PM. N.J.A.C. 8:39-31.2(e)	K0222		
K0321 SS = F	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the	K0321	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THE RESIDENTS AFFECTED BY THE DEFICIENT PRACTICE A self-closing door mechanism was installed on the door to the Nursing Suite to meet requirements of the National Fire Protection Association (NFPA). The door was tested and verified to function properly, fully closing and latching.	08/26/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315386	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - NEW BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLAS REHABILITATION AND HEALTHCARE AT MAYWOOD	100 WEST MAGNOLIA AVENUE , MAYWOOD, New Jersey, 07607

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K0321 SS = F	Continued from page 4 areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This STANDARD is NOT MET as evidenced by: Based on observations and interview on 08/05/2025 in the presence of the U.S. FOIA (b) (6)) and the U.S. FOIA (b) (6) from a sister facility (U.S. FOIA (b) (6 it was determined that the facility failed to ensure that hazardous areas were separated from other spaces by smoke resisting partitions and doors in accordance with NFPA 101:2012 Edition, Sections 8.4 and 19.3.5.9. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 9:57 AM revealed that the nursing suite was being used to store combustibles. The room was over 50 sq. ft. and was not provided with self-closing door or automatic closing door. In an interview at the time, the U.S. FO and the U.S. FOIA (b	K0321	Continued from page 4 The Maintenance Director immediately re-educated all department managers that combustible storage may only be kept in properly protected areas. HOW WILL THE FACILITY IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THIS SAME DEFICIENT PRACTICE All residents have the potential to be affected by this deficient practice. WHAT MEASURES WILL BE PUT IN PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT OCCUR The Maintenance Director or designee inspected all rooms over 50 square feet to ensure that any used for combustible storage are equipped with compliant self-closing or automatic-closing doors. The Maintenance Director or designee re-educated staff on proper storage practices and the requirement that hazardous areas be separated from other spaces by self-closing or automatic-closing doors. HOW WILL THE FACILITY MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR The Maintenance Director or designee will conduct weekly audits for three (3) weeks, then monthly audits for three (3) months, to verify that all hazardous areas are separated from other spaces by self-closing or automatic-closing doors. Any issues identified will be immediately corrected by the Maintenance Director or designee and the Administrator will be notified of all findings. The Administrator or designee will review the findings in the monthly Quality Assurance and Performance Improvement (QAPI) Committee meeting for a minimum of three months, with continuation as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315386	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - NEW BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/11/2025

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ATLAS REHABILITATION AND HEALTHCARE AT MAYWOOD	100 WEST MAGNOLIA AVENUE , MAYWOOD, New Jersey, 07607

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K0321 SS = F	Continued from page 5 confirmed the finding. The facility's U.S. FOIA (b) (6) U.S. FOIA (b) (6) and U.S. FOIA (b) (6) were notified of the deficient practice at the Life Safety Code survey exit conference on 08/06/2025 at 2:47 PM. N.J.A.C. 8:39-31.2(e)	K0321		
K0345 SS = F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This STANDARD is NOT MET as evidenced by: Based on record review and interview on 08/06/2025 in the presence of the U.S. FOIA (b) (6)) , it was determined that the facility failed to ensure that the fire alarm system was tested, repaired and maintained in accordance with the requirements of NFPA 70, National Electrical Code, NFPA 72, National Fire Alarm and Signaling Code, and NFPA 101:2012 Edition, Section 9.6.1.3, 9.6.1.5. This deficient practice had the potential to affect all residents and was evidenced by the following: A review of documentation provided by US FO at 8:00 AM revealed the fire alarm "Inspection and Testing Report" dated 05/13/2025 indicated the following devices failed inspection and no documentation was available indicating any repairs had been made: -First floor smoke detectors #38, #42, #43, #49, #55, #56 -Second floor smoke detectors #69, #75, #76, #82, #83, #90, #99, #100 Further record review revealed that there was no record that sensitivity testing was performed on the smoke	K0345	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS AFFECTED BY THE DEFICIENT PRACTICE The Maintenance Director immediately contacted the fire alarm vendor to replace the identified smoke detectors which failed inspection and to schedule sensitivity testing of all smoke detectors. The replacement of the identified smoke detectors and the sensitivity testing is scheduled to be completed on 8/29/25. HOW WILL THE FACILITY IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THIS SAME DEFICIENT PRACTICE All residents have the potential to be affected by this deficient practice. WHAT MEASURES WILL BE PUT IN PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT OCCUR The Maintenance Director or designee will ensure that all inspection reports are reviewed immediately upon receipt, and any deficiencies are addressed promptly with the fire alarm vendor. The Administrator re-educated the Maintenance staff on National Fire Protection Association (NFPA) requirements for fire alarm testing and maintenance. HOW WILL THE FACILITY MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR	09/15/2025

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K0345 SS = F	Continued from page 6 detectors. No documentation was provided regarding repairs/replacement of smoke detectors and sensitivity testing. In an interview at 12:45 PM, the [redacted] and the [redacted] confirmed the findings. The facility's [redacted] and [redacted] were notified of the deficient practice at the Life Safety Code survey exit conference on 08/06/2025 at 2:47 PM. N.J.A.C. 8:39-31.2 (e) NFPA 70,72	K0345	Continued from page 6 The Maintenance Director or designee will review fire alarm inspection and testing reports to verify that all devices are functional, and sensitivity testing is documented. The Maintenance Director or designee will conduct quarterly audits for three (3) quarters to confirm documentation of repairs and that testing is up to date and available in the Emergency Preparedness binder. The Administrator will review audit results at the facility's quarterly Quality Assurance and Performance Improvement (QAPI) Committee meetings for a minimum of three quarters.	
K0353 SS = F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on record review and interview on 08/06/2025 in the presence [redacted]), it was	K0353	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THE RESIDENTS AFFECTED BY THE DEFICIENT PRACTICE On 08/06/2025, the contracted sprinkler vendor was contacted by the Maintenance Director to provide the missing quarterly inspection reports and to schedule any overdue inspections or testing. Copies of the quarterly sprinkler reports and 5 year hydrostatic test were obtained and placed in the Emergency Preparedness binder. The fire hydrant annual inspections were completed on 8/22/25 and copies were placed in the Emergency Preparedness Binder. The 3-year air leak test was completed on 8/27/25 and the copy was placed in the Emergency Preparedness Binder. HOW WILL THE FACILITY IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THIS SAME DEFICIENT PRACTICE All residents have the potential to be affected by this deficient practice. WHAT MEASURES WILL BE PUT IN PLACE OR SYSTEMIC CHANGES	08/27/2025

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K0353 SS = F	Continued from page 7 determined that the facility failed to ensure that fire sprinkler systems were inspected tested and maintained in accordance with NFPA 101:2012 Edition, Sections 9.7.5, 9.7.6, 9.7.7, 9.7.8 and NFPA 25:2010 Edition, Sections 4.4, 4.5, 4.7, 4.1.4, 5.2.1 and 14.2. This deficient practice had the potential to affect all residents and was evidenced by the following: A record review at 1:10 PM revealed the following: 1. The quarterly sprinkler reports dated 09/20/2024 (Q1), 12/27/2024 (Q2), 03/31/2025 (Q3), and (Q4) were not provided. 2. No records were provided for 2 of 2 fire hydrant annual inspections/tests. 3. No record was provided for the fire department hydrostatic 5-year test. 4. No record was provided for the 3-year air leak test. No further documentation was provided. In an interview at 1:45 PM, the U.S. FOIA acknowledged the findings. The facility's U.S. FOIA (b) (6) U.S. FOIA (b) (6) and U.S. FOIA (b) (6) were notified of the deficient practice at the Life Safety Code survey exit conference at 2:47 PM. N.J.A.C. 8:39-31.2 (e) NFPA 13. 25	K0353	Continued from page 7 MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT OCCUR The Maintenance Director or designee will ensure reports are obtained from the vendor within 10 business days of each completed service and filed in the Emergency Preparedness binder. The Administrator re-educated the Maintenance staff on National Fire Protection Association (NFPA) 101 requirements for inspection, testing, and maintenance of water-based fire protection systems. HOW WILL THE FACILITY MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR The Maintenance Director or designee will audit the Emergency Preparedness binder monthly for three (3) months to verify mandatory inspections and reports are current and complete. The Administrator will review audit results at the facility's monthly Quality Assurance and Performance Improvement (QAPI) Committee meeting for a minimum of three months.	
K0521 SS = E	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This STANDARD is NOT MET as evidenced by:	K0521	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS AFFECTED BY THE DEFICIENT PRACTICE The contracted Heating Ventilation Air Conditioning (HVAC) vendor was contacted to repair or replace non-functioning ventilation fans in the identified rooms. All repairs were completed, and bathroom ventilation systems were tested and confirmed operational. HOW WILL THE FACILITY IDENTIFY OTHER RESIDENTS HAVING	08/28/2025

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K0521 SS = E	Continued from page 8 Based on observations and interview on 08/05/2025 in the presence of the U.S. FOIA (b) (6) it was determined that the facility failed to maintain ventilation in resident bathrooms in accordance with NFPA 101:2012 Edition, Sections 19.5.2, 9.2.1 and NFPA 90 A, Standard for the Installation of Air-Conditioning and Ventilating Systems. This deficient practice had the potential to affect 44 of 111 residents and was evidenced by the following: Observations during the tour between 9:11 AM to approximately 2:57 PM revealed the following: Second floor resident rooms #202, #204, #206, #208, #210, #212, #214, #216, #217, #219, #221, #223, #225, #227, #228, #226, #224, #222, #220, #218, #229 and #231-bathroom ventilation systems were not functioning. Third floor resident rooms #302, #304, #406, #308, #310, #312, #314 and #316-bathroom ventilation systems were not functioning. In an interview at 2:51 PM, the U.S. FO confirmed and acknowledged the exhaust fans in resident's rooms were not functioning when tested. The facility's U.S. FOIA (b) (6) U.S. FOIA (b) (6) and U.S. FOIA (b) (6) were notified of the deficient practice at the Life Safety Code survey exit conference on 08/06/2025 at 2:47 PM. N.J.A.C. 8:39-31.2(e) NFPA 90A	K0521	Continued from page 8 THE POTENTIAL TO BE AFFECTED BY THIS SAME DEFICIENT PRACTICE Residents residing in rooms 202, 204, 206, 208, 210, 212, 214, 216, 217, 219, 221, 223, 225, 227, 228, 226, 224, 222, 220, 218, 229, 231, 302, 304, 306, 308, 310, 312, 314, and 316 have the potential to be affected by this deficient practice. WHAT MEASURES WILL BE PUT IN PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT OCCUR The Maintenance Director or designee inspected all resident bathroom ventilation systems to ensure functionality. Preventive maintenance procedures were updated to include quarterly checks of all bathroom exhaust systems. The Maintenance Director re-educated all nursing and housekeeping staff to promptly report any issues with bathroom ventilation. HOW WILL THE FACILITY MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR The Maintenance Director or designee will conduct weekly checks of 3 random resident room ventilation systems for three (3) weeks, then monthly checks for three (3) months. Any malfunctioning ventilation will be immediately reported and repaired. The Administrator will review the audit results at the facility's monthly Quality Assurance and Performance Improvement (QAPI) Committee meeting for a minimum of three months.	
K0531 SS = F	Elevators CFR(s): NFPA 101 Elevators 2012 EXISTING	K0531	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR RESIDENTS AFFECTED BY THE DEFICIENT PRACTICE On 08/06/2025, the Maintenance Director contacted the contracted elevator service company to immediately schedule inspection, testing, and re-certification of	11/03/2025

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K0531 SS = F	Continued from page 9 Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3 This STANDARD is NOT MET as evidenced by: Based on record review and interview on 08/06/2025 in the presence U.S. FOIA (b) (6)), it was determined that the facility failed to inspect, test and maintain 2 of 2 elevators in accordance with the New Jersey Department of Community Affairs Elevator Safety Division, New Jersey Uniform Construction Code, ASME A 17.1/CSA B 44, Safety Code for Elevators and Escalators and NFPA 101: 2012 Edition, Sections 19.5.3, 9.4,9.4.2, and 9.4.6. This deficient practice had the potential to affect all residents and was evidenced by the following: A record review at 12:01 PM revealed the following: 1. Two of 2 temporary certificate of occupancy/compliance were issued on 06/12/2023 and expired 09/30/2023. 2. No documentation was provided for 2 of 2 elevator annual Fire Service Operations Phase 1 and Phase 2 testing. 3. No documentation regarding regularly scheduled monthly preventive maintenance and testing of Fire Service Operation Phase 1 and Phase 2 were not provided. In an interview at 12:45 PM, the U.S. FO confirmed the findings and acknowledged documentation was not provided.	K0531	Continued from page 9 both facility elevators. On 8/22/25, both elevators received annual Fire Service Operations Phase I and Phase II testing. On 8/26/25, The Maintenance Director confirmed with the town of Maywood that the elevator inspection was completed on 7/23/25 without concerns. Facility is awaiting official document/certificate of compliance which will be placed in the Emergency Preparedness Binder upon arrival. Upon further follow up, facility was notified on 11/3/25 that another re-inspection was deemed necessary and was immediately scheduled. HOW WILL THE FACILITY IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THIS SAME DEFICIENT PRACTICE All residents have the potential to be affected by this deficient practice. WHAT MEASURES WILL BE PUT IN PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT OCCUR The Maintenance Director or designee reviewed all facility elevator records to confirm up-to-date documentation of certification, annual fire service operation testing, and monthly preventive maintenance. The Administrator re-educated the maintenance staff on the state requirements for elevator certification and National Fire Protection Association (NFPA) 101 elevator safety standards. HOW WILL THE FACILITY MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR The Maintenance Director or designee will review elevator service and inspection documentation monthly for three (3) months to ensure records are current and available. The Maintenance Director will present a quarterly audit of elevator certification and Fire Service Operation	

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K0531 SS = F	Continued from page 10 The facility's U.S. FOIA (b) (6) the U.S. FOIA (b) (6) and U.S. FOIA (b) (6) were notified of the deficient practice at the Life Safety Code survey exit conference on 08/06/2025 at 2:47 PM. N.J.A.C. 8:39-31.2 (e) ASME A 17.1/CSA B 44	K0531	Continued from page 10 testing records to the facility's quarterly Quality Assurance and Performance Improvement (QAPI) Committee for at least three (3) quarters. Any discrepancies will result in immediate corrective action and follow-up with the elevator service provider.	
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 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 observations, record review and interview on 08/05/2025 and 08/06/2025 in the presence of the U.S. FOIA (b) (6)) and the U.S. FOIA (b) (6) from a sister facility (U.S. FOIA (b) (6) it was determined that the facility failed to ensure that that all fire door assemblies were inspected, tested and maintained annually in accordance with 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: Observations on 08/05/2025 revealed fire door/smoke doors in various locations in the facility including stairway enclosures.	K0761	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS AFFECTED BY THE DEFICIENT PRACTICE The Maintenance Director conducted the annual inspections of fire door assemblies. Written records of the fire door inspections were obtained and filed in the Emergency Preparedness Binder for surveyor review. HOW WILL THE FACILITY IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THIS SAME DEFICIENT PRACTICE All residents have the potential to be affected by this deficient practice. WHAT MEASURES WILL BE PUT IN PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT OCCUR The Maintenance Director or designee reviewed all facility doors requiring inspection under National Fire Prevention Association (NFPA) 80 and created an inventory list with locations and inspection due dates. The Administrator re-educated the maintenance staff on the importance of fire door function and inspection, including to immediately report any fire door that does not properly close or latch. Copies of annual inspection reports will be maintained in the Emergency Preparedness Binder and readily available for review. HOW WILL THE FACILITY MONITOR ITS CORRECTIVE ACTIONS TO	08/27/2025

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ATLAS REHABILITATION AND HEALTHCARE AT MAYWOOD	100 WEST MAGNOLIA AVENUE , MAYWOOD, New Jersey, 07607

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K0761 SS = F	Continued from page 11 A documentation review on 08/06/2025 revealed that documentation for the annual inspections of fire door assemblies was not included in the records that were provided for review. In an interview at 1:45 PM, the [redacted] confirmed the review and stated that he would check the office for the documentation. No additional documentation for the annual fire door assembly inspections was provided. The facility's [redacted] and [redacted] were notified of the deficient practice at the Life Safety Code survey exit conference at 2:47 PM. N.J.A.C 8:30-31.2 (e) NFPA 80	K0761	Continued from page 11 ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR The Maintenance Director or designee will verify that all fire door assemblies are inspected annually and that written documentation is on file. Weekly for 3 Weeks and then Monthly for three (3) months, the Maintenance Director or designee will conduct spot-checks on 3 randomly selected fire doors to ensure they are closing and latching properly. The Administrator will review the results of the audits at the facility's monthly Quality Assurance and Performance Improvement (QAPI) Committee meeting for a minimum of three (3) months.	
K0918 SS = F Bldg. 02	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 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	K0918	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS AFFECTED BY THE DEFICIENT PRACTICE Maintenance Director immediately contacted the contracted generator service company to provide a copy of the annual diesel fuel sample analysis test. Documentation of the completed 2025 diesel fuel analysis has been placed in the Emergency Preparedness binder and is available for surveyor review. HOW WILL THE FACILITY IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THIS SAME DEFICIENT PRACTICE All residents have the potential to be affected by this deficient practice. WHAT MEASURES WILL BE PUT IN PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT OCCUR The Administrator re-educated the maintenance staff on	08/22/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315386	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - NEW BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLAS REHABILITATION AND HEALTHCARE AT MAYWOOD	100 WEST MAGNOLIA AVENUE , MAYWOOD, New Jersey, 07607

(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
K0918 SS = F Bldg. 02	Continued from page 12 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 Documentation review and interview on 08/06/2024 in the presence of the U.S. FOIA (b) (6)), it was determined that the facility failed to ensure that the emergency and standby power generator diesel fuel quality was tested annually and maintained in accordance with NFPA 110 Standard for Emergency and Standby Power Systems (2010 Edition) Section 8.3.8. This deficient practice had the potential to affect all residents and was evidenced by the following: A review of the facility's generator annual service report dated 05/05/2025 provided by the U.S. FO revealed no record that diesel fuel sample analysis test had been conducted. No further documentation was provided regarding a diesel fuel sample analysis test had been conducted. In an interview at 1:45 PM, the U.S. FO confirmed the findings. The facility's U.S. FOIA (b) (6) U.S. FOIA (b) (6) and U.S. FOIA (b) (6) were notified of the deficient practice at the Life Safety Code survey exit conference at 2:47 PM. N.J.A.C 8:39-31.2(e), 31.2(g) NFPA 99, 110	K0918	Continued from page 12 NFPA 110 requirements regarding generator maintenance and documentation. HOW WILL THE FACILITY MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR The Maintenance Director or designee will verify that diesel fuel quality analysis is conducted annually and that documentation is maintained in the Emergency Preparedness binder. The Administrator will review the generator maintenance binder quarterly for the next four (4) quarters to confirm compliance. Results of the annual generator fuel sample analysis testing will be reviewed during the facility's Quality Assurance and Performance Improvement (QAPI) Committee for at least four (4) consecutive meetings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315386	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLAS REHABILITATION AND HEALTHCARE AT MAYWOOD	100 WEST MAGNOLIA AVENUE , MAYWOOD, New Jersey, 07607

(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
E0000	Initial Comments An Emergency Preparedness Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 08/05/25 and 08/06/25. The facility was found not to be in compliance with the requirement for participation in Medicare/Medicaid at 42 CFR, Subpart 483.73, Emergency Preparedness.	E0000		08/19/2025
E0039 SS = F	EP Testing Requirements CFR(s): 483.73(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional	E0039	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THE RESIDENTS AFFECTED BY THE DEFICIENT PRACTICE Documentation on a tabletop disaster drill conducted on 2/11/25 was located and placed in the Emergency Preparedness Binder. HOW WILL THE FACILITY IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THIS SAME DEFICIENT PRACTICE All residents have the potential to be affected by this deficient practice. WHAT MEASURES WILL BE PUT IN PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT OCCUR The Administrator re-educated the U.S. FOIA (b) (6) on the training requirements and frequency to test the emergency plan and to maintain all documentation in the Emergency Preparedness Binder. Training requirements include a group discussion led by a facilitator using a narrated, clinically relevant emergency scenario and a set of problem statements, directed messages, or prepared questions designed to challenge the Emergency Preparedness Plan. HOW WILL THE FACILITY MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR	08/19/2025

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: 315386	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLAS REHABILITATION AND HEALTHCARE AT MAYWOOD	100 WEST MAGNOLIA AVENUE , MAYWOOD, New Jersey, 07607

(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
E0039 SS = F	Continued from page 1 exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or	E0039	Continued from page 1 The Maintenance Director will conduct monthly audits x 6 months to ensure drill frequency requirements and documentation are maintained. The Administrator will monitor audit results during monthly QAPI committee meetings x 2 quarters to ensure compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315386	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/11/2025

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E0039 SS = F	Continued from page 2 (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct	E0039		

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E0039 SS = F	Continued from page 3 exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the	E0039		

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E0039 SS = F	Continued from page 4 emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following:	E0039		

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E0039 SS = F	Continued from page 5 (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency	E0039		

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E0039 SS = F	Continued from page 6 plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360]	E0039		

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E0039 SS = F	Continued from page 7 (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This STANDARD is NOT MET as evidenced by: Based on review of the facility's Emergency Preparedness Manual and interview on 08/06/2025, it was determined that the facility failed to conduct the required two exercises to test the emergency plan at least annually. This deficient practice had the potential to affect all residents and was evidenced by the following: A review the facility's Emergency Preparedness Manual for the time frame of August 11,2023 to August 14, 2024, revealed there was no evidence that the facility participated in a community-based full-scale exercise.	E0039		

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E0039 SS = F	Continued from page 8 The facility conducted a facility-based disaster drill on Wednesday, August 14, 2024, but did not conduct the required second full-scale exercise. This exercise was required to be community-based, individual facility based or tabletop exercise. Included must be a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency. In an interview with both the facility U.S. FOIA (b) (6) and the U.S. FOIA (b) (6) at 12:15 PM, both stated that the facility did not conduct the required second drill for the time frame August 11, 2023 to August 14, 2024, but have scheduled another disaster drill on Tuesday, August 12, 2025. The facility's U.S. FOIA (b) (6) U.S. FOIA (b) (6) and U.S. FOIA (b) (6) were notified of the deficient practice at the Life Safety Code survey exit conference on 08/06/2025 at 2:47 PM. NJAC 8:39-31.2(e), 31.6(o)	E0039		
E0041 SS = F	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e), §485.542(e) (e) Emergency and standby power systems. The [LTC facility CAH and REH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.542(e)(1), §485.625(e)(1)	E0041	WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THE RESIDENTS AFFECTED BY THE DEFICIENT PRACTICE The emergency fuel agreement was placed in the Emergency Preparedness binder. HOW WILL THE FACILITY IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THIS SAME DEFICIENT PRACTICE All residents have the potential to be affected by this deficient practice. WHAT MEASURES WILL BE PUT IN PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT OCCUR The Administrator re-educated the U.S. FOIA (b) (6) on emergency fuel supply requirements and that documentation must be kept in the Emergency	08/22/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315386	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLAS REHABILITATION AND HEALTHCARE AT MAYWOOD	100 WEST MAGNOLIA AVENUE , MAYWOOD, New Jersey, 07607

(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
E0041 SS = F	Continued from page 9 Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2), §485.542(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3),§485.542(e)(2) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), REHs at §485.542(g), and and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park,	E0041	Continued from page 9 Preparedness Binder. HOW WILL THE FACILITY MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR The Maintenance Director will conduct monthly audits x3 months to ensure the emergency fuel agreement is in place and in binder. The Administrator will monitor audit results during monthly Quality Assurance Performance Improvement (QAPI) committee meetings x3 months to ensure compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315386	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLAS REHABILITATION AND HEALTHCARE AT MAYWOOD	100 WEST MAGNOLIA AVENUE , MAYWOOD, New Jersey, 07607

(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
E0041 SS = F	Continued from page 10 Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. This STANDARD is NOT MET as evidenced by: Based on review of the facility's Emergency Preparedness Manual and interview on 08/06/2025, it was determined that the facility failed to ensure the emergency preparedness policy plan included how the facility would maintain generator power/fuel during an emergency. This deficient practice had the potential to affect all residents and was evidenced by the following: A review of the facility's Emergency Preparedness policy, contained in a binder titled "Emergency Preparedness" and provided by the U.S. FOIA (b) (6), revealed that the policy did not include provisions for maintaining fuel supply during an emergency. In an interview at 12:45 PM, the U.S. FO confirmed the findings. The facility's U.S. FOIA (b) (6) U.S. FOIA (b) (6)	E0041		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315386	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLAS REHABILITATION AND HEALTHCARE AT MAYWOOD	100 WEST MAGNOLIA AVENUE , MAYWOOD, New Jersey, 07607

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E0041 SS = F	Continued from page 11 U.S. FOIA (b) (6) and U.S. FOIA (b) (6) were notified of the deficient practice at the Life Safety Code survey exit conference on 08/06/2025 at 2:47 PM. N.J.A.C. 8:39-31.2 (e)	E0041		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315386	A. BUILDING 02 - NEW BUILDING B. WING	11/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLAS REHABILITATION AND HEALTHCARE AT MAYWOOD	100 WEST MAGNOLIA AVENUE , MAYWOOD, New Jersey, 07607

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K0000 Bldg. 02	INITIAL COMMENTS An onsite revisit was conducted on 11/14/2025 to verify the facility's Plan of Correction for the 8/11/2025 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		11/24/2025

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: 315386	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATLAS REHABILITATION AND HEALTHCARE AT MAYWOOD	**100 WEST MAGNOLIA AVENUE , MAYWOOD, New Jersey, 07607**

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E0000	Initial Comments An on-site revisit was conducted on 11/14/2025 to verify the facility's Plan of Correction for the 8/11/2025 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		11/24/2025

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